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## **Evaluation of the Encouraging Better Practice in Aged Care (EBPAC) initiative: final report**

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July 2015

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## Abbreviations used in this report

ACSIHAG	Aged Care Services Improvement Healthy Ageing Grant
BHS	Ballarat Health Services
CALD	Culturally and Linguistically Diverse
CHSD	Centre for Health Service Development, University of Wollongong
DoHA (the Department)	Commonwealth Department of Health and Aging
EBP	Evidence Based Practice
EBPAC	Encouraging Best Practice in Aged Care
EBPRAC	Establishing Best Practice in Residential Aged Care
INTVWs	Interviews
LEAP	The Lifestyle Engagement and Activity Program
LUPP	Leg Ulcer Prevention Program
RACF	Residential Aged Care Facility
RACP	Registered Aged Care Provider
SAP	Skin Awareness Program
TRACS	Teaching and Research Aged Care Services

## Abbreviations for EBPAC projects

CL1	Bridging the Leadership Skill Gap
CL2	Clinical Mentoring: From Evidence-Base To Outcomes For Older People
CC1	Better Practice For Older People Living With Or At Risk Of Chronic Wounds In The Community
CC2	The Lifestyle Engagement And Activity Program (LEAP) For Life Project (Social Engagement And Physical Activity)
CC3	Home-Based Preferred Music Listening Program
CC4	CHOICES In CDC Aged Care
CC5	Building Better Oral Health Communities
CC6	Person-Centred Dementia Support In The Community
RC1	National Implementation Of The Palliative Approach Toolkit For Residential Aged Care Facilities
RC2	National Rollout of the Evidence Based Champions for Skin Integrity Program
RC3	The Sustainable Culture Change In Residential Aged Care Project

## Key messages

This third round of the Encouraging Better Practice in Aged Care (EBPAC) Program extends its reach from residential to community aged care, and included projects that addressed systemic issues of leadership and change in the sector.

It has been an important piece of the Australian Government's significant investment over recent years in aged care sector development initiatives that are designed to facilitate the delivery of evidence based best practice to aged care clients.

The eleven projects discussed in this report have reached several thousand aged care employees, and built capacity amongst the many project leaders, team members and participants.

The program has developed and strengthened intra- and inter-sector partnerships and, significantly, initiated and/or revived enthusiasm and commitment amongst those directly responsible for the day to day support and care of aged care clients.

Strategic imperatives of consumer directed care, wellness and enablement, quality improvement and partnership development underpinned many of the activities.

Projects developed a number of important evidence based resources which can continue to inform the sector.

Importantly, the program has added to the understanding of knowledge translation within aged care contexts as the projects included elements of this emerging research field within their activities.

Their experiences have confirmed the multiplicity of factors that impact on implementing new practices, and highlighted the importance of stakeholder input and multi-level strategies to support implementation and sustainability.

## Executive summary

The Encouraging Better Practice in Aged Care (EBPAC) program has been funded by the Australian Government over three rounds with the aim of encourage the uptake of evidence-based practice in both the residential and community aged care sectors. This Round Three initiative is an extension of the former Encouraging Better Practice in Residential Aged Care (EBPRAC) Program (Rounds 1 and 2) which funded 13 projects focussing solely on residential aged care.

The EBPAC program consists of eleven projects with the broad objective of achieving practice and evidence-based improvements for people receiving aged care services, staff providing those services, the aged care system and the broader community. The majority of projects were funded for a two and a half year period between June 2012 and December 2014. There were three broad groups of projects: leadership and organisational change; evidence translation in community care; and evidence translation in residential aged care (two national roll-out projects).

Each of the projects, with the exception of the three projects targeting residential aged care specifically, featured a lead organisation working with consortium members to implement evidence translation projects focussed on specific clinical and/or care practice areas. Lead organisations included a TAFE, a university, a peak state body and five community service providers. Two of the other three projects focussing primarily on residential aged care were led by universities and the other by a state health department.

Each project conducted their own project level evaluation focussing on a 'before and after' design, i.e. measuring a series of variables before implementation commenced and then measuring the same set of variables after implementation of the evidence. Many activities were undertaken both to change practice and to collect evaluation data. The program-level evaluation, distinct from the evaluation of individual projects, was based on a framework to examine the delivery and impact of the program on consumers, providers and the aged care system. Data was collected for the program evaluation from stakeholder interviews and surveys, six-monthly project progress reports, visits to lead organisations and a series of evaluation tools aimed at measuring dissemination, training materials and the roll-out of national workshops.

The implementation strategies adopted across the 11 projects were wide-ranging. Each project used a mix of different types of evidence and theory to support practice changes, support the development of particular models and underpin their approach to implementation. Three of the projects built on the work carried out in the previous two funding rounds. The implementation strategies across the 11 EBPAC projects involved some form of education and/or training with the main goal of improving the knowledge and skills of aged care providers. Each project developed their own materials to use with staff, basing them on existing evidence or clinical guidelines but they adapted them to suit the perceived needs of the specific audience.

Implementation of the program proceeded as planned. Some delays were experienced during the 'establishment' phase due to the withdrawal of participating services and the

need to recruit replacements and some difficulties recruiting and retaining staff and clients. Both of the national roll-out projects experienced delays in developing resources.

Each of the five projects operating in the community aged cares sector featured a person-centred approach with one project aiming to increase client involvement in decision making, two projects having a strong emphasis on client self-management, one project promoting psychosocial activities for clients and one using music to improve client mood and reduce carer stress. At the core of a person-centred approach is the ability of staff to engage with clients and carers and each project included multiple opportunities for engaging with clients in new ways. Not surprisingly, the ability to engage with clients was an important enabler of implementation, usually in the form of conversations between staff and clients. This was carried out with some success by each of the community-based projects. Barriers to client engagement included; working with cognitively impaired clients, lengthy education sessions, cultural differences between staff and clients and the ability of clients to comprehend the written or spoken word.

For the community projects there was little evidence of overt resistance from managers or staff to the practice changes. More typically, there was a lack of enthusiasm in some quarters but this was usually due to a lack of understanding of the proposed changes and could usually be tempered by the provision of more staff education. Staff were more likely to be engaged with the EBPAC project where the changes in practice were 'observable' where you could 'see the benefits' in client outcomes. It was apparent that it was important for the community-based projects to have people at all levels of the organisation providing support for implementation of evidence-based practice. Where this came from was not as important as the fact that it came from somewhere. Overall, the presence of support helped implementation and the absence of support hindered implementation.

One feature of the community-based projects was the fact that the EBPAC project was being delivered in a system of care delivery involving many competing priorities. Typical challenges to implementation included; the additional cost of implementing new practice, allocating time for client education, the different priorities of both staff and clients and the competing priorities of day-to-day tasks. However, many of the projects were able to provide strategies to address these challenges. These included ensuring that client education was succinct, negotiating with clients to resolve competing priorities in order to introduce something new and encouraging clients to develop a simple routine for looking after their own care.

For the leadership and change projects the most important enabler was a receptive context for change. This included support of managers, the commitment of those involved in the projects and the availability of sufficient resources (particularly time and funding) to participate in the project. Conversely, the major barrier encountered by the leadership and change projects involved instances where the context within which they were operating was not receptive to change i.e. lack of management support, insufficient time and resources to support participation and lack of staff commitment. However, the lack of staff commitment tended to be limited and dissipated as staff came to see the benefits of what was taking place. An important enabling ingredient was a focus on working in project teams with a multi-disciplinary approach. In teams, staff came to understand their own role and the

contribution they could make which was seen as ‘validating’ their own abilities and instilling confidence.

The outcomes of the program on consumers were difficult to measure. Three of the four leadership and change projects did not directly measure consumer outcomes as part of their evaluation methodology. However, stakeholder interviews carried out by the national evaluation team suggested some positive outcomes for consumers. The fourth project that did evaluate consumer outcomes had mixed evaluation results.

Five of the six community care projects included practice changes targeted specifically at consumers. The projects’ own evaluations were able to demonstrate some improvements in consumer outcomes but the results were very general in nature. Stakeholder interviews carried out by the national evaluation team were not able to elicit any positive consumer outcomes.

The two national roll-out projects were not directly responsible for changing practices in facilities and therefore they did not include any direct implementation strategies targeted at residents. Rather, any practice changes targeted at residents arising from these two projects were determined by those attending the workshops and other staff in their facilities.

There was considerable more data available to the evaluation team with regards to measuring outcomes on providers. Three of the four leadership projects were able to demonstrate improved levels of confidence, empowerment and competence in the staff that participated in the different work groups. The community-based projects were able to demonstrate an improvement in job satisfaction and increased levels of knowledge and confidence. The two national roll-out projects did not collect detailed data relating to resident outcomes however stakeholder interviews and surveys carried out by the national evaluation team highlighted that, in some instances, the use of evidence based practice had improved as a result of a heightened sense of staff awareness and understanding.

All projects included consideration of the broader system implications in one way or another, reflecting their requirements of the overall program evaluation. All participating organisations benefitted directly from EBPAC by accessing various training resources. As a result the sector has the potential to have a much richer skill set amongst a proportion of its staff which could, to some extent, result in improved outcomes for clients. Also, improved access to evidence based resources and tools and the development of research and project management skills is now more widespread. The system also benefited from improved relationships that aged care organisations developed and/or strengthened as a result of participating in EBPAC. These included links with academic institutions, mainstream services, and inter- and cross-sector organisations.

Collectively, the three rounds of EBPAC represent a significant investment to improve the delivery of evidence-based practice for aged care recipients whether they reside in a facility or in the community. Aged care workers have been upskilled through their participation in training events such as workshops. Tools have been developed to promote organisational uptake of the innovations and effort has been made to align innovations with regulatory frameworks and strategic reforms. Importantly, the EBPAC program has also resulted in a

better understanding of what works in aged care, and what needs to be in place in order for innovations to succeed. The heterogeneous and dynamic nature of the aged care sector means there is no one simple formula to facilitating change in a consistent and coherent manner.

The complex interaction between consumer, workforce, organisational and systemic factors will continue to pose challenges to the provision of evidence-based practice and will need to be explicitly addressed to ensure the benefits of any future investments are realised.

## 1 INTRODUCTION

This is the final report from the Centre for Health Services Development on the evaluation of the EBPAC program. CHSD was engaged in September 2012 to evaluate the program which ran between June 2012 and December 2014.

### 1.1 Background to the EBPAC Program

Under the EBPAC program, eight projects were funded that aimed to encourage the uptake of evidence-based practice in the aged care sector. In addition three projects were funded under the ACSIHAG initiative. EBPAC represented an extension of the former EBPRAC Program under which 13 projects were funded in two rounds (rounds 1 and 2) between December 2007 and December 2010. The key difference with the EBPAC initiative is that it included a number of projects that worked with older people living in the community. In addition, three projects were funded under the ACSIHAG initiative. For convenience, this report refers to the 11 projects as EBPAC projects.

### 1.2 Links between the current program and earlier rounds

The previous evaluation of rounds 1 and 2 concluded with a series of 15 recommendations covering the establishment of a central agency to support the ongoing implementation of evidence-based practice in residential aged care; linking the use of evidence with the system of accreditation; developing clinical leaders to support the implementation of evidence-based practice; maximising the impact of what had been learnt from rounds 1 and 2; and the funding of future projects. Many of the recommendations have not been acted upon directly (e.g. the establishment of a central agency) but some components of Round 3 are consistent with the recommendations:

- Two projects (CL1, CL2) developed models for training clinical leaders, consistent with a recommendation regarding clinical leadership. As was noted in the evaluation report for rounds 1 and 2 (p 80), 'without a focused effort on developing clinical leadership there will continue to be limits to the extent to which evidence-based practice is initiated, implemented and sustained, within individual facilities and across the sector'.
- Two projects (RC1 and RC2) delivered nation-wide workshops to disseminate current evidence in the areas of palliative care and skin care, consistent with recommendations to maximise the impact of what had been learnt in rounds 1 and 2.
- A web page to disseminate selected resources from each round of the program is currently being developed, consistent with a recommendation about disseminating existing evidence and another recommendation about establishing a central web-based repository which can serve as a 'one stop shop' for resources to support implementation of evidence-based practice.

### 1.3 EBPAC and ASCIHAG Objectives

The decision to conduct a single national evaluation of the Round 3 EBPAC and recent ACSIHAG projects reflected the clear synergies that existed between the objectives of the two initiatives. The overall objective of both initiatives was to achieve practice and evidence-based improvements for people receiving aged care services, staff providing those

services, the aged care system and the broader community. The types of improvements that were expected include:

### **1.3.1 Improvements for recipients of aged care services**

#### **EBPAC:**

- Improve clinical and personal care for recipients of Australian Government subsidised aged care services

#### **ACSIHAG:**

- Support activities that promote healthy and active ageing
- Support activities that provide information and support to assist carers maintain their caring role
- Support to services providing aged care to Aboriginal and Torres Strait Islander people and people living in remote areas
- Support people from culturally and linguistically diverse (CALD) backgrounds

### **1.3.2 Improvements for staff**

#### **EBPAC:**

- Provide opportunities for aged care and health workforce to enhance their knowledge and skills to support the uptake of evidence-based, person centred, aged care practice
- Support staff to access and translate the best available evidence into everyday practice

#### **ACSIHAG:**

- Support activities that build the capacity of aged care services to deliver high quality care

### **1.3.3 System improvements**

#### **EBPAC:**

- Showcase innovative Australian evidence-based, person centred, aged care practice, including through encouraging partnerships between aged care providers, education and research organisations
- Widely disseminate and promote established, evidence-based, person centred aged care practice, including through encouraging partnerships between aged care providers, education and research organisations
- Develop, maintain and promulgate resources that support evidence-based, person centred, aged care practice and inform ongoing development of, and assessment against, relevant standards
- Contribute to development of the aged care evidence base through evaluation of projects that translate into everyday practice

#### **ACSIHAG:**

- Respond to existing and emerging challenges, including dementia care

## **1.4 Individual project aims and objectives**

From this point forward, EBPAC and ACSIHAG projects are referred to as EBPAC projects.



Across the EBPAC initiative, there were three broad groups of projects: clinical leadership; evidence translation in community care; and evidence translation in residential aged care. For convenience we have referred to the two clinical leadership projects as CL1 and CL2, the six evidence translation in community care projects as CC1 to CC6 and the three evidence translation in residential aged care projects as RC1 to RC3.

It is clear that there are both common elements and differences across the three groups of projects, such as target audiences, planned outcomes or impacts, whether they build on existing models/information, and proposed change mechanisms being used. For example, four projects (CL1, RC1-3) were focusing their efforts on residential aged care, with the remaining projects focusing primarily on community aged care services. Within these groups, however, there were a mix of target audiences and outcomes expected. Five projects appeared to be focusing their interventions on management and/or clinical leaders (CL1, CL2, CC6, RC1 and RC3), five targeting care staff (CC2, CC3, CC4, CC5, RC1 and RC2) and one seeking to influence consumers as well as clinicians to improve clinical practices (CC1). Three of the four projects targeting leaders were seeking to facilitate organisational or structural impacts and outcomes (CL2, CC6, RC3), with the remaining project (CL1) seeking to achieve clinical and/or care practice impacts and outcomes, along with the remaining eight projects.

It also appears that six projects were building on work already underway or completed, including two trialling the transfer of processes developed for the residential aged care sector to the community sector (CC2 and CC5), one translating clinical guidelines into practice (CC1) and another building on an existing project, the seed funding for which was provided by another agency (CC6).

The eight projects funded under the EBPAC initiative each featured a lead organisation that worked with consortium members to implement evidence translation projects focussed on specific clinical and/or care practice areas. The three projects funded under the ACSIHAG initiative comprised two projects that were national roll-outs of the previous Encouraging Best Practice in Residential Aged Care Program and one which aimed to develop a national approach to organisational culture change.

The structure of the eleven projects to be evaluated is shown in Table 1.

**Table 1** *Projects funded under the EBPAC and ACSIHAG initiatives*

#	Funding initiative	Project	Lead organisation	Implementation sites
CL1	EBPAC	Bridging the leadership skill Gap	Dept of Ed and Training (QLD) and Metropolitan South Institute of TAFE (MSIT) (QLD)	Twenty five RACFs in SA, NSW and Qld
CL2	EBPAC	Clinical Mentoring: from evidence-base to outcomes for older people	Resthaven Incorporated (SA)	Eleven aged care services in Qld, NT and SA
CC1	EBPAC	Better practice for older people living with or at risk of chronic wounds in the community (wound	Royal District Nursing Service	Five Community Aged Care Services in Vic and WA

#	Funding initiative	Project	Lead organisation	Implementation sites
		management)		
CC2	EBPAC	The Lifestyle Engagement and Activity Program (LEAP) for Life Project (social engagement and physical activity)	University of NSW	Six community aged care services in Sydney, Central Coast, Bathurst and the Illawarra
CC3	EBPAC	Home-based Preferred Music Listening Program (emotional well-being)	Chinese Community Social Services Centre Inc. (Vic)	Five Community Aged Care Services in Vic
CC4	EBPAC	Choices in CDC Aged Care	Uniting Care Community Options (Vic)	Aged Care Providers assisting up to 200 clients in VIC, NSW and ACT
CC5	EBPAC	Building Better oral health Communities	South Australian Dental Services	Five aged care providers in SA and NSW (including Indigenous communities)
CC6	EBPAC	Person-centred Dementia Support in the Community	Alzheimer's Australia (Vic)	Five aged care providers in each state and territory
RC1	ACSIHAG	National rollout of The Palliative Approach Toolkit for residential aged care facilities	Qld Health	National roll out
RC2	ACSIHAG	Improving Wound Management for Residents in Residential Aged Care Facilities project	Queensland University of Technology	National roll out
RC3	ACSIHAG	The Sustainable Culture change in Residential Aged Care Project	University of Western Australia/ Curtin University/ RSL Care	Four residential aged care facilities in WA and four residential aged care facilities in Qld

There are similarities and differences in the change strategies being utilised across the projects.

### 1.5 Targeted literature review

In 2013, members of the evaluation team undertook a targeted literature review to identify the factors that are considered important to assist in the ability of those working in the community care sector to access and implement evidence based practice.

Literature published since 2000 was considered and numerous databases were reviewed including PubMed, Cochrane Database, Medline and Cinahl. In addition, a snowball approach was used, reviewing references in key articles, as well as searching websites that are known to contain information on the subject, e.g., the Canadian Health Services Research Foundation, the Department of Health and Ageing and the US Centre for Disease Control and Prevention.

The review revealed a greater need for community services to work in partnership and in collaboration, the need for the alignment of philosophical ideas and policies, organisational

design factors that address administrative and clinical factors, and coordination and boundary spanning linkage mechanisms. The review is available in Appendix 1.

## 2 EVALUATION METHODOLOGY

Our evaluation strategy has been designed in order to allow the evaluation team to form a judgment as to how successfully the EBPAC initiatives have been implemented, whether the desired results have been achieved and what lessons have been learnt that will lay the ground-work for the sustained use of evidence-based practice in residential and community aged care.

The evaluation assesses the outcomes of the projects funded under the EBPAC initiatives and identifies critical success factors to inform future national rollout or wider promulgation of evidence-based materials and resources from the successful projects. Key information for this was obtained from a set of evaluation tools described in section 2.2.

Our evaluation of the EBPAC projects drew extensively on the aggregated findings from the project evaluations provided in their final reports. This was supplemented by data provided through the site visits and stakeholder interviews as summarised in Table 3. The project final reports and the records of the site visits and stakeholder interviews were loaded into NVivo software, which was used to facilitate data analysis.

The program evaluation drew extensively on the aggregate findings of the project evaluations, constituting a ‘meta-evaluation’ of project achievements, constraints and successes. Given the diversity of projects there were no common clinical outcomes, hence improvements in clinical care were only identified by project-level evaluations.

This was supplemented by our knowledge gleaned from our experience in conducting the national evaluation of Rounds 1 and 2 of EBPAC. This was supported by a targeted literature review focussing on the evidence relating to implementing evidence based practice within a community care context (see Appendix 1).

### 2.1 The CHSD Evaluation Framework

The foundation of our evaluation is a framework (referred to as ‘the CHSD evaluation framework’). It is represented by a matrix with three levels of analysis on the vertical axis ensuring we explore the impact and outcomes for consumers (including carers, their families and friends), providers and the broader aged care sector (refer to Figure 1).

Across the horizontal axis of the matrix are six key issues that a comprehensive evaluation should address – program delivery, program impact, sustainability, capacity building, generalisability and dissemination. Through systematically exploring each of the six key issues or questions posed, where possible at each level of the framework, we will address the formative and summative requirements of this evaluation.

**Figure 1 CHSD Evaluation Framework**

EVALUATION HIERARCHY	What did you do?  PROGRAM / PROJECT DELIVERY	How did it go?  PROGRAM / PROJECT IMPACT	Can you keep going?  PROGRAM / PROJECT SUSTAINABILITY	What has been learnt?  PROGRAM / PROJECT CAPACITY BUILDING	Are your lessons useful for someone else?  PROGRAM / PROJECT GENERALISABILITY	Who did you tell?  DISSEMINATION
<b>Level 1</b>	<b>Impact on, and outcomes for, consumers (clients, families, carers, friends, communities)</b>					
Outcomes, indicators and measures to be developed for each cell as relevant	Describe what was implemented and, if necessary, contrast to what was planned	Impact on consumers and carers	Sustainability assessment	Capacity building assessment	Generalisability assessment	Dissemination log
<b>Level 2</b>	<b>Impact on, and outcomes for, providers (staff, formal carers, professionals, volunteers, organisations)</b>					
Outcomes, indicators and measures to be developed for each cell as relevant	Describe what was implemented and, if necessary, contrast to what was planned	Impact on professionals, volunteers, organisations	Sustainability assessment	Capacity building assessment	Generalisability assessment	Dissemination log
<b>Level 3</b>	<b>Impact on, and outcomes for, the system (structures, processes, networks, relationships)</b>					
Outcomes, indicators and measures to be developed for each cell as relevant	Describe what was implemented and, if necessary, contrast to what was planned	System level impacts, including external relationships	Sustainability assessment	Capacity building assessment	Generalisability assessment	Dissemination log

## 2.2 Evaluation approach

While the overall EBPAC initiatives were seeking to have an impact at each of the three levels identified in the framework, this was not necessarily the case for individual projects. In some instances, not all cells within the CHSD Evaluation Framework were relevant. For example, individual projects may have been aiming to have an impact at one, two or all three of these levels. However the discipline of reviewing each cell of the matrix ensures we explored all potential project and program impacts and outcomes.

For several projects, the evaluation of impacts and outcomes primarily focused on the provider and system levels. Based on our experience, it can be quite difficult to measure impacts of time-limited initiatives on individuals who have a progressive illness or disease trajectory and attribute those impacts to the particular intervention, given the multi-factorial aspects associated with ageing clients.

In developing our evaluation framework, we have identified a set of data collection requirements that have been implemented to support the national evaluation. We have aimed to strike a balance between minimising the data collection burden placed on individual projects whilst ensuring that sufficient information is available to produce a robust national evaluation. In some cases, we have asked projects (or participating aged care services) to complete specific tools at key points during the evaluation. In other cases, we have collected information directly through site visits, on-line questionnaires, surveys or stakeholder interviews.

Our Evaluation Framework document developed in February 2013 comprised a suite of seven evaluation tools. Some of these were sourced (or modified) from the published literature, whilst others were developed specifically for the purpose of this evaluation. More details about the seven tools are provided below:

### **2.2.1 Tool 1 Project six monthly report**

The progress report has been designed to collect data in a systematic way to meet the requirements for reporting to the Department and to inform the program evaluation. It was completed by the projects at six monthly intervals. Each project completed four progress reports over the project period.

### **2.2.2 Tool 2 Project expenditure breakdown report**

The concept of developing an expenditure breakdown tool was to identify the key cost implications of the EBPAC initiative. However, the Evaluation Team decided in October 2014 not to pursue the development of this tool. Similar tools we have used previously and others that we have reviewed have proved to be either too complex and/or detailed, or too simplistic to allow us to draw any program-wide conclusions given the variety and nature of the projects funded. In place of this, we have drawn on the financial information provided in each projects four progress reports together with the information provided in the final audited statement of receipts and expenditure.

### **2.2.3 Tool 3 Project dissemination log**

The rationale behind the dissemination log was to record details of any public dissemination of project outputs. This information has assisted us in answering a range of evaluation questions across several domains of inquiry.

### **2.2.4 Tool 4 Training materials evaluation questionnaire**

Many EBPAC projects developed or refined training materials or resources to be implemented across the aged care sector using a variety of delivery models. For some projects, materials were targeted at staff of aged care organisations, whilst other materials were delivered directly to aged care consumers. The purpose of this questionnaire was to support our evaluation of the materials developed across EBPAC projects.

### **2.2.5 Tool 5 Project workshop log**

The purpose of this tool was to assist in answering evaluation questions particularly related to assessing the reach of workshops. The tool is only used to record workshop activity conducted by the two national roll-out projects.

### **2.2.6 Tool 6 Project workshop notification/recruitment tool**

Again, this tool was intended only for the use of the two national roll-out projects. Its purpose was to capture information regarding strategies employed in planning, convening and reviewing workshops and assisted in assessing the different strategies employed by these two projects.

### **2.2.7 Tool 7 Stakeholder interviews**

A series of stakeholder interviews were conducted by the evaluation team to collect information on the views and experiences of EBPAC stakeholders. A semi-structured interview format was adopted to allow issues to be explored in more depth than is possible through questionnaires.

Tools 3, 4, 5 and 6 were supported by Word or Excel templates that were emailed to the projects.

### 2.2.8 Other evaluation activities

In addition to information collected through these formal evaluation tools, we also undertook a range of related activities to support the EBPAC projects and our evaluation method. A brief outline of these is provided below.

#### National workshops

The evaluation team facilitated two national workshops during the evaluation. The first workshop was held in Canberra on 11 October 2012. The second national EBPAC workshop was held at the Park Royal Hotel, Melbourne Airport on 22 July 2014. Both workshops were facilitated by CHSD in its role as the EBPAC national evaluator.

The first (orientation) workshop was held prior to the commencement of data collection activities in order to introduce the evaluation team to the relevant project contacts and generate their support for and involvement in the evaluation. The workshop also sought feedback about the proposed EBPAC evaluation approach, e.g. data collection tools, local evaluation activities, communication strategies, ethics and EBPAC project progress reports.

The second workshop provided an opportunity for the evaluation team to discuss emerging evaluation issues with projects and to offer any support that may be required regarding evaluation, report writing or dissemination of results.

Feedback from participants indicated that both workshops were extremely well received. They provided an excellent opportunity for projects to network and share ideas and strategies. Detailed workshop evaluation reports are available in Evaluation Progress Reports 1 and 2.

#### Site visits

Our evaluation plan allowed for two site visits to be undertaken to each project over the course of the evaluation. At the commencement of the evaluation, a primary and secondary evaluation team member was allocated for each EBPAC project and site visits were conducted by both team members.

The initial round of evaluation site visits occurred between November 2012 and February 2013. The visits represented a critical source of information that fed into the development of the evaluation framework. They also provided an important opportunity for the evaluation team to familiarise itself with the details of each project and meet the key people involved.

The second site visit provided an opportunity to collect data from members of the project team relating to project implementation and project governance. Key evaluation questions were explored relating to project delivery, stakeholder engagement, costs and funding, evaluation, sustainability, generalisability, capacity building and enablers and barriers to project implementation.

In addition, a small number of additional site visits were conducted to support projects that were experiencing difficulties.

### **Ethics approval**

An application for ethical approval for the program evaluation was approved by the University of Wollongong / Illawarra Area Health Service Human Research Ethics Committee on 22/3/2013 (HE13/107).

Each EBPAC project was responsible for determining their own ethics approval requirements and for submitting required applications to the relevant ethics committee. In most cases, projects determined at an early stage that ethics approval would be required and submitted ethics applications with no involvement from the evaluation team. For a small number of projects, the national evaluation team provided support and advice regarding the need for and process of obtaining relevant ethics approval. Three projects did not obtain ethics approval.

### **2.3 Evaluation of the national roll-out projects**

As noted, three of the eleven EBPAC projects were funded under the ACSIHAG program. Two of these involve the national roll-out of resources developed under Round 2 of EBPRAC:

- (RC1) National Rollout of the Palliative Approach Toolkit – Queensland Health, and
- (RC2) National Rollout of the Evidence Based Champions for Skin Integrity Program – Queensland University of Technology (QUT).

Both projects had similarities in their approach and were distinct from other projects. Each had a focus on the dissemination of evidence based resources (toolkits) to support high quality care in the residential aged care sector (one supporting end-of-life care and the other in wound management) and each had a train the trainer approach supported by the roll-out of national workshops.

As a result of the similarities between these projects a common evaluation methodology was developed. It was hoped that this would help to identify critical success factors that may inform future national rollouts of evidence-based materials and resources.

The delivery of each project involved three main developmental stages as highlighted below:

- Stage 1: Workshop planning (evaluation questions include, what evidence base supported the delivery of the workshops and how were they advertised?)
- Stage 2: Running workshops (evaluation questions include how the workshops were rated by the participants?)
- Stage 3: Toolkit implementation (evaluation questions include to what degree were aspects of the Toolkit implemented in residential aged care?)

Capturing data about Stage 1 (workshop planning) was primarily collected through the use of Evaluation Tool 4: Training materials evaluation questionnaire, Evaluation Tool 5: Project workshop log and Evaluation Tool 6: Project workshop notification/recruitment tool.



Capturing data about the workshops themselves and the implementation of the toolkit (Stages 2 and 3) was collected through a series of stakeholder interviews and surveys. Semi-structured interviews were used with key stakeholders to address issues relating to change management, knowledge transfer and context for implementation. These were carried out with RACF managers, quality managers and workshop participants within RACFs where the PA Toolkit and the CSI Toolkit have been implemented.

Evaluation Tool 7 also included the option of using an on-line survey approach as an alternative or in concert with stakeholder interviews. We felt that it was important to use both interviews and surveys as part of our evaluation methodology for the two national roll-out projects. The surveys were targeted at workshop participants and the interviews were targeted at RACF managers and quality managers.

Both the online survey tool and the interview protocol were developed in consultation with both the national roll-out projects.

### 2.3.1 National roll-out interviews

As mentioned above telephone interviews were used to capture data relating to change management, knowledge transfer and context for implementation. As it was not practical to interview stakeholders from each RACF represented at both the palliative care and CSI workshops, a stratified sampling approach was applied to capture data from a representative sample of RACFs. The sampling approach is summarised in the following section.

The interviews took place between April 2014 and December 2014. In total, 40 interviews were carried out for RC2 and 31 for RC1. A detailed report of these interviews can be found at Appendix 2 and 3.

### 2.3.2 National roll-out interviews sampling method

To obtain the required number of facilities to conduct telephone interviews for those who had received training from the RC1 and RC2 projects a sampling framework was developed (see section 5.1.1 in Evaluation Progress Report 4). The sampling framework ensured that a representative sample of 40 services was selected by stratifying for jurisdiction, location and size. Table 2 provides an outline of the sampling framework.

Each state and territory was sampled separately, except for ACT and NSW, which were combined. Location was defined using the postcode of the facility and linking this to the Australian Standard Geographical Classification (ASGC) to determine if it was a metropolitan or rural/regional location.<sup>1</sup> For all jurisdictions, except NT and Tasmania, a facility's location was considered Metro if the ASGC code was 0 (Major Cities of Australia) and Rural/regional otherwise. For NT and Tasmania the ASGC codes 0 (Major Cities of Australia) and 1 (Inner Regional Australia) were used to identify Metro facilities. Service size was defined by the number of beds in the facility. A small service is defined as an RACF with less than 50 beds and a large service was an RACF with 51 or more beds.

<sup>1</sup><http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Standard+Geographical+Classification+%28ASGC%29>

**Table 2** *Sampling methodology for telephone interviews*

State/Territory:	number required (number sampled)	Location	Number required (number sampled)	Size of Service	Number required (number sampled)
NSW/ACT	8 (24)	Metro	4 (12)	Large: Small	2 (6) : 2 (6)
		Rural/regional	4 (12)	Large: Small	2 (6) : 2 (6)
Vic	8 (24)	Metro	4 (12)	Large: Small	2 (6) : 2 (6)
		Rural/regional	4 (12)	Large: Small	2 (6) : 2 (6)
Qld	8 (24)	Metro	4 (12)	Large: Small	2 (6) : 2 (6)
		Rural/regional	4 (12)	Large: Small	2 (6) : 2 (6)
WA	4 (12)	Metro	2 (6)	Large: Small	1 (3) : 1 (3)
		Rural/regional	2 (6)	Large: Small	1 (3) : 1 (3)
SA	4 (12)	Metro	2 (6)	Large: Small	1 (3) : 1 (3)
		Rural/regional	2 (6)	Large: Small	1 (3) : 1 (3)
NT	4 (12)	Metro	2 (6)	Large: Small	1 (3) : 1 (3)
		Rural/regional	2 (6)	Large: Small	1 (3) : 1 (3)
Tas	4 (12)	Metro	2 (6)	Large: Small	1 (3) : 1 (3)
		Rural/regional	2 (6)	Large: Small	1 (3) : 1 (3)
Total number of facilities: 40 (120)					

A random sample of facilities was selected to fill the sampling framework. A list of facilities was obtained from the training records for the Pall Care and CSI projects. The CSI projects provided a list of the name, email contact and phone number of workshop attendees as well as their facility name, state and full address. Additional information of the facility bed numbers and main telephone number was obtained from the Residential Aged Care Australia website<sup>2</sup>.

The Palliative Care Project only provided the facility name, state and postcode of workshop attendees. In view of this an additional database was purchased from A-ZGovBIZ<sup>3</sup> that provided the facility name, full address, contact name and telephone number and bed numbers, which was linked to the original list using facility name and postcode.

For each facility a number was generated using the random number generator in Microsoft Excel and within each cell facilities were ordered by their number in ascending order. Starting from the top of each cell, facilities were selected for interview. This was repeated until the required number of interviews was achieved for all cells.

### 2.3.3 National roll-out surveys

As mentioned, online surveys were used to capture data relating to the delivery of both the RC1 and RC2 workshops and implementation of the respective toolkits.

<sup>2</sup> <http://www.agedcareguide.com.au/residential-aged-care-australia.asp>

<sup>3</sup> <http://azgovbiz.com.au/>

Both survey tools were targeted at participants of the CSI workshops and were made available online using the SurveyMonkey<sup>®4</sup> website. In total, 557 surveys were completed (278 of RC1 and 299 for RC2). A detailed report of these surveys can be found at Appendix 3.

### 2.3.4 Evaluation of remaining EBPAC projects

The remaining nine EBPAC projects worked with a consortium of aged care and health care services to implement a range of initiatives that aimed to promote better practice in the aged care sector.

These projects also had similarities with regards to their implementation methods. All were implementing a new model of care which was supported by the development of resources and targeted training.

Again, given the similarities between these projects a common evaluation methodology was developed to help identify critical success factors that may inform the future national rollout of evidence-based materials and resources in the specific areas being addressed by these projects.

Again, the delivery of these nine self-contained projects involved three main developmental stages as highlighted below:

- Stage 1: Resource development (evaluation questions include, what evidence base supported the delivery of the initiative?)
- Stage 2: Recruitment (evaluation questions include how were aged care staff supported to participate in the project?)
- Stage 3: Implementation (evaluation questions include to what degree were aspects of the project incorporated into aged care practice?)

Capturing data about Stage 1 (resource development) was primarily collected through the use of Evaluation Tool 4: Training materials evaluation questionnaire. Additional data was captured through the site visits and project reporting.

Capturing data about Stage 2 (recruitment) was carried out through the projects progress reports and final report. Questions relating to implementation (Stage 3) were answered through semi-structured interviews with key stakeholders. The focus here was on collecting data relating to change management, knowledge transfer and the context for implementation. The interviews took place between April 2014 and December 2014 with members of the project team, consortium members, RACF managers and quality managers. The number of interviews is highlighted in Table 3.

**Table 3**      *Number of interviews carried out*

#	Project	Number of interviews carried out	Number of interviewees
CL1	Bridging the leadership skill Gap	5	9
CL2	Clinical Mentoring: from evidence-base to outcomes for older people	8	12

<sup>4</sup> <https://www.surveymonkey.com/>

#	Project	Number of interviews carried out	Number of interviewees
CC1	Better practice for older people living with or at risk of chronic wounds in the community (wound management)	7	7
CC2	The Lifestyle Engagement and Activity Program (LEAP) for Life Project (social engagement and physical activity)	6	8
CC3	Home-based Preferred Music Listening Program (emotional well-being)	2 Interviews plus one focus group	15
CC4	Choices in CDC Aged Care	8	10
CC5	Building Better oral health Communities	5	7
CC6	Person-centred Dementia Support in the Community	4	7
RC3	The Sustainable Culture change in Residential Aged Care Project	9	13
<b>Total</b>		<b>55</b>	<b>88</b>

## 3 PROJECT DELIVERY

### 3.1 Project groupings

The EBPAC Program includes a diverse mix of projects, employing different methodologies designed to achieve a wide range of outcomes. From the documentation provided to the evaluation team at the outset, we categorised the projects according to their primary target audiences, i.e., clinical leadership (CL1 and CL2, community care (CC1 – CC6) and residential aged care (RC1 – RC3). These groupings are not mutually exclusive, for example, both clinical leadership projects involved residential aged care and community care. Also, the approach taken in the two clinical leadership projects is very similar to the approach taken in one of the residential aged care projects (RC3). Some projects focused on implementing changes in practices that will benefit consumers during the lifetime of the project (e.g. the CC5) whereas the focus in some projects was on developing resources which could be used by others at a later date to implement practice change (e.g. the CC6 and RC3 projects).

As the projects commenced the implementation phase we were able to provide greater clarity in terms of their common elements; this in turn lent itself to a slight reframing of the categories where their primary impacts and outcomes were aligned with the three levels of the evaluation framework (consumers, providers, system).

Therefore, in reporting on program delivery we have grouped the projects according to the 'level' of the CHSD Evaluation Framework that they primarily impacted on, as summarised in Figure 2.

- Projects that primarily impacted on the system that included the development of models for training clinical leaders (CL1 and CL2) and facilitating organisational change (RC3 and CC6).
- Projects that aimed to implement evidence-based practice in community care (CC1, CC2, CC3, CC4, CC5).
- Projects that delivered nation-wide workshops to disseminate current evidence in the areas of palliative care and skin care (RC1 and RC2).

**Figure 2** *Main focus of activity of EBPAC projects according to the CHSD evaluation framework*

	Leadership and change projects				Community care projects					National roll-out projects	
Evaluation Hierarchy	CL1	CL2	CC6	RC3	CC1	CC2	CC3	CC4	CC5	RC1	RC2
Level 1: Impacts on, and outcomes for Consumers											

	Leadership and change projects				Community care projects					National roll-out projects	
Evaluation Hierarchy	CL1	CL2	CC6	RC3	CC1	CC2	CC3	CC4	CC5	RC1	RC2
<b>Level2:</b> Impacts on, and outcomes for Providers											
<b>Level 3:</b> Impacts on, and outcomes for the System											

Importantly, those projects that mainly focus on one or two levels were not limited to having an impact only at that level. For example, while the two national roll-out projects were designed to impact on providers and the system, it was expected that workshop participants would return to their residential aged care facilities and implement changes which would, in turn, benefit residents as well.

### 3.2 Project evidence

Each project used a mix of different types of evidence and theory to support practice changes, support the development of particular models and underpin their approach to implementation (Table 4). Some projects used one or two main sources of evidence whereas others used a variety of sources. There was less emphasis on published clinical guidelines than in Round 1 and Round 2, with a greater emphasis on building on the work done in previous projects, particularly in the earlier rounds of the program.

**Table 4** Evidence base for each project

Project	Evidence
CL1	There is little in the way of evidence from aged care to guide the development of training resources for leadership programs so the project drew on the wider leadership literature to underpin the program they developed. The framework for the project is based on the concept of 'shared' leadership i.e. all staff have the potential to make a contribution to leadership.
CL2	This project was influenced by a review of the literature on clinical mentoring education programs. The main source referred to in the project final report is <i>Mentoring in Nursing and Healthcare: A Practical Approach</i> by Kilgallon & Thompson, published in 2012. Training of clinical mentors was underpinned by two theories of change management. Each of the action research projects triggered by the main project was based on relevant clinical guidelines (primarily developed in Australia) e.g. pain management, wound management.
CC1	The Leg Ulcer Prevention Program was based on the Australian Wound Management Association Clinical Practice Guideline for the Prevention and Management of Venous Leg Ulcers. The Skin Awareness Program was based on the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury and other international clinical guidelines.

Project	Evidence
CC2	The evidence for the LEAP model was based on previous research conducted by the project lead and evidence from residential aged care that psychosocial activity-based interventions can improve resident outcomes. Project design was based on evidence from the diffusion of innovations and implementation science literature. The training program was developed based on the evidence about how best to deliver training in aged care.
CC3	The project was based on research evidence indicating that there are therapeutic benefits to be gained from elderly people listening to music.
CC4	The project adapted an existing model of self-directed care, the People at Centre Stage (PACS) model, for services in metropolitan areas to meet the particularly needs of clients in rural, Greek and ATSI communities. The evaluation of the PACS model has recently been published. <sup>5</sup> Adaptation of the model was based on consultations with clients, carers, and service providers.
CC5	This project built on work undertaken by the <i>Better Oral Health in Residential Care</i> project in Round 1 to improve the oral health of people in residential aged care by implementing evidence-based guidelines. Development and implementation of the model was guided by the PARIHS knowledge translation framework (Promoting Action on Research Implementation in Health Services).
CC6	The project resources were developed based on a review of literature, expert advice and consultations with consumers.
RC1	The Palliative Approach Toolkit was developed by the CEBPARAC project in Round 2, primarily based on the Australian Government Department of Health and Ageing <i>Guidelines for a palliative approach in residential aged care</i> published in 2006. <sup>6</sup> The guidelines are due to be updated in 2016.
RC2	This project built on work undertaken by the <i>Creating Champions for Skin Integrity</i> project in Round 2 to improve wound management. For the current project, the evidence base was updated to incorporate the latest evidence, resulting in evidence-based guidelines covering different aspects of wound management. This comprehensive evidence base was distilled into 2-3 page guideline summaries which provided the basis for the educational resources developed by the project.
RC3	The TOrCCh (Towards Organisational Culture Change) materials were developed during the project with input from participants, based on the lessons learnt during a previous pilot. The TOrCCh process was influenced by the literature on quality improvement, action research and practice development.

### 3.3 Project implementation

There is often confusion about what is meant by the term ‘implementation’. For some projects, particularly the two national roll-out projects, implementation primarily consisted of delivering workshops at multiple sites across the country. For the community projects, implementation was about implementing changes to the care delivered to clients.

As with previous evaluations, we have found it useful to distinguish between practice changes that are experienced by consumers and the strategies that are used to bring about those practice changes (referred to as implementation strategies). The aim is to effectively implement practice changes that are known to be effective so that good consumer outcomes are achieved.<sup>7</sup> This is generally achieved by building organisational capacity, which can be considered as operating at two levels: (1) the expertise (skills, knowledge and experience) of individual staff; (2) the resources, processes and procedures that facilitate organisations to use the expertise of individuals more productively.<sup>8</sup>

<sup>5</sup> Ottmann, G & Mohebbi, M (2014) *Self-directed community services for older Australians: a stepped capacity-building approach*. *Health and Social Care in the Community*, 22(6): 598–611.

<sup>6</sup> CEBPARAC stands for Comprehensive Evidence Based Palliative Approach in Residential Aged Care

<sup>7</sup> Fixsen DL, Naoom SF, et al. (2005). *Implementation research: a synthesis of the literature*. Tampa, Florida, University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

<sup>8</sup> Schuh RG. & Leviton LC (2006) *A framework to assess the development and capacity of non-profit agencies*. *Evaluation and Program Planning*, 29(2): 171-179.

Examples of implementation strategies to build organisational capacity and effect practice change (framed in terms of our evaluation framework) are as follows:

- Level 1: Consumers – strategies (e.g. education) to change the behaviour of consumers.
- Level 2: Providers – strategies to change the behaviour of individual staff e.g. education, distribution of educational materials, audit and feedback.
- Level 3: System - strategies e.g. use of champions to facilitate change, local consensus processes such as action learning teams, changes in systems or processes.

The following discussion provides an overview of the main activities undertaken by projects to build organisational capacity; these are discussed in more detail in Sections 3.4, 3.5 and 3.6.

### 3.3.1 Implementation strategies

All of the implementation strategies across the 11 EBPAC projects involved some form of education and/or training with the main goal of improving the knowledge and skills of aged care providers. As was the case with the earlier EBPAC rounds, on the whole, projects developed their own materials to use with staff, basing them on existing evidence or clinical guidelines but adapted to suit the perceived needs of the specific audience. The general approach of the majority of projects was the need to work closely with each aged care organisation, and provide learning opportunities in a style and format that was flexible and responsive to the needs and circumstances of that particular organisation, the staff involved, the client profile and the context within which care was being delivered. To that end, a number of strategies were used, including:

- Various collaborative approaches including action research and Plan-Do-Study-Act cycles
- Structured training programs delivered in a group format such as workshops
- Self-directed web-based learning modules
- Informal, opportunistic learning
- Training of mentors/champions

Education is typically central to any program for promoting evidence-based practice, either alone or in combination with other strategies. Education that is more interactive seems to be more effective in changing practices than didactic education, although the effect tends to be small<sup>9</sup>, and education outreach has a small to modest effect.<sup>10</sup> There has been little work on the effectiveness of inter-professional collaboration and education.<sup>11</sup> A recent review of the literature on the role of education and training for residential aged care staff concluded that education is necessary but not sufficient for change and that the outcomes of such education 'are equivocal and that benefits for residents are variable, neither always detectable or statistically significant, nor persistent. Nonetheless, the literature describes a

<sup>9</sup> Forsetlund, L., A. Bjørndal, et al. (2009). *Continuing education meetings and workshops: effects on professional practice and health care outcomes*. [Cochrane Database of Systematic Reviews](#) 2.

<sup>10</sup> O'Brien, M. A., S. Rogers, et al. (2007). *Educational outreach visits: effects on professional practice and health care outcomes*. [Cochrane Database of Systematic Reviews](#) 4.

<sup>11</sup> Reeves, S., M. Zwarenstein, et al. (2008). *Interprofessional education: effects on professional practice and health care outcomes*. [Cochrane Database of Systematic Reviews](#) 1.



formidable range of positive outcomes for residents'<sup>12</sup> (p 418). From a human resource management perspective it is interesting to note that research into the effectiveness of training has generally focused on outcomes for individuals who attend the training, rather than the organisations they work for.<sup>13</sup>

Workshops were the primary mode for delivering training (nine projects); for two projects, the primary mode for delivery was the completion of self-directed learning packages, in CL2 by clinical mentors and in RC3 by the work teams formed to facilitate change. Some of the resources developed by CC5 can be used as a self-learning package (by staff). Virtually all the training resources included elements of theory and practice. When asked to identify the strongest component of their training packages, projects most frequently mentioned the useability of the resources (simplicity, flexibility) and the evidence on which the resources were based.

The quality of the learning experience for participants was monitored and evaluated by most projects, typically with the use of surveys before and/or after workshop attendance. For the three projects involving action learning/action research projects, the outcomes of those projects were a measure of the learning experience.

Action learning is 'learning from concrete experience and critical reflection on that experience, through group discussion, trial and error, discovery and learning from one another'.<sup>14</sup> Action research is defined in various ways but typically involves the simultaneous use of data gathering, feedback and action which can serve the dual purpose of being a research method as well as a process for bringing about change.<sup>15</sup> Within the context of the EBPAC program, the two are effectively the same.

The 'cycle of change' approach used in the action learning projects is consistent with the various quality improvement methodologies developed over the last 25 years which, despite superficial differences, typically involve four main elements – a cycle of improvement, the use of different techniques and tools to facilitate the improvement cycle, recognition of the organisational dimension of improvement (e.g. management support) and involvement of frontline staff.<sup>16</sup>

### 3.3.2 Development of resources

Each project devoted considerable time and expertise to the development of training resources, primarily targeting staff within residential aged care or community care. The section in the projects' final report about 'new resources developed' yielded a range of information, from details of major resources developed for use elsewhere to other, more minor, resources developed specifically for project use. Tables summarising the major

<sup>12</sup> Nolan, M., S. Davies, et al. (2008). 'The role of education and training in achieving change in care homes: a literature review.' *Journal of Research in Nursing* 13: 411-433.

<sup>13</sup> Tharenou, P., A. M. Saks, et al. (2007). *A review and critique of research on training and organizational-level outcomes. Human Resource Management Review* 17: 251-273.

<sup>14</sup> Zuber-Skennett, O (1993) *Improving learning and teaching through action learning and action research. Higher Education Research and Development*, 12(1): 45-58.

<sup>15</sup> Bate P (2000) *Synthesizing research and practice: using the action research approach in health care settings. Social Policy & Administration*, 34(4): 478-493.

<sup>16</sup> Walshe K (2009) *Pseudoinnovation: the development and spread of healthcare quality improvement methodologies. International Journal for Quality in Health Care*, 21(3): 153-159.

resources developed by each project are included in the individual project summary tables in Appendix 2. In addition, each project developed various handouts, newsletters, flyers, brochures, presentations and audit tools, all designed specifically for their project and not necessarily intended for use elsewhere. Details of these resources have not been included in the tables.

Some projects were underpinned by a particular approach to change management and developed resources to support its implementation and sustainability. This was particularly the case with the RC3 project which developed an integrated package to facilitate organisational change.

Projects completed Evaluation Tool 4 (Training materials evaluation questionnaire) which included questions about the type of resources developed, the audience for the training materials, the process of developing the training materials and the content of the training materials. In general, training resources built on existing resources or what had been learnt from previous projects, supplemented with evidence from the literature. All produced hard copies of training resources in various forms (resource kits, workbooks, bathroom prompts, information sheets), in some cases supported with audio-visual materials (e.g. CC5) and online resources. The majority of the resources were developed in consultation with clinicians and aged care providers. Four projects involved consumers in the development of resources (CC1, CC2, CC5 and RC2).

### 3.4 Leadership and change projects

Four projects focused on the system level to either develop clinical leaders (and the training resources to develop clinical leaders in the future) or develop resources to facilitate organisational change. This is illustrated by the main deliverables of the four projects:

- Emerging Leaders training materials
- Aged Care Clinical Mentor Model of Change
- The TOrCCh Toolkit
- The Valuing People resources

#### 3.4.1 Leadership and change project implementation

The main implementation strategies employed by the projects were action research and organisational assessment processes. Three of the projects adopted either an action learning or action research approach (the exception being the CC6 project). These projects supported the action learning/research with a mentor or facilitator, although the RC3 Organisational Change project aimed to develop a Toolkit which would allow staff to implement the TOrCCh process without external facilitation (Table 5).

**Table 5** *Implementation strategies and practice changes, leadership and change projects*

Implementation strategies	Practice changes
CL1	
Funding to cover the cost of staff training. Mentors to support action learning teams. Training program for mentors. Multidisciplinary teams in each facility to undertake an action learning project	As determined by each action learning team, in areas such as palliative care, oral health, falls prevention, hydration and

Implementation strategies	Practice changes
in a clinical area of choice. Six one-day leadership workshops for team members. Additional strategies in each facility as chosen by action learning teams.	the care of those with dementia.
CL2	
Funding for clinical mentors (2 days/week) and champions (1 day/week). Clinical mentors in each facility or community service. Champions to support the clinical mentors. External clinical mentor coach to support the clinical mentors. Web-based networking tool to facilitate peer networking and support for clinical mentors. Workshops for clinical mentors and champions. Additional strategies identified in the action plan developed by the action research project in each aged care service, in one of four clinical areas.	As determined by clinical mentors, in collaboration with champions and other staff within their organisation (in the areas of pain management, wound management, dementia care and manual handling).
RC3	
Action learning teams formed in participating facilities with work of the teams guided by the TORCCh model. External facilitator to support action learning teams. Project sponsor (usually the facility manager) with responsibility and accountability for the team and their project. Additional strategies in each facility as chosen by action learning teams.	Small-scale changes in each facility, as determined by each action learning team.
CC6	
Workshops for providers to explain the resources (which can assist organisations to provide person-centred services). Hard copies of resource document distributed to providers.	Nil (project limited to development and distribution of the resources)

The three action learning/action research projects all involved a team of people working together to decide on a course of action, plan that course of action, learn from the experience of implementation and reflect on what they had done to inform future action. The CL2 project employed an explicit 6-step process: (1) identify a clinical priority area, (2) engage with manager and other stakeholders, (3) develop an action plan, (4) implement (using various mentoring activities to support implementation), (5) evaluate and (6) sustain the changes. The TORCCh (RC3) model employed a 4-step process – question, plan, act, and reflect. The CL1 project was less explicit with its ‘cycle of change’ approach but still incorporated four ‘core elements’ – learning to change, leading change and innovation, communication, action learning – depicted as a circle (around the core concept of person-centred care). The remaining project (CC6) was based on the Plan Do Study Act (PDSA) model of quality improvement, triggered by conducting an organisational self-assessment to identify opportunities for improving person-centeredness.

### 3.4.2 Leadership and change projects resource development

Details of these resources are summarised in Table 6. The two projects focusing on sector leadership both involved residential aged care facilities and community aged care providers; RC3 only involved residential aged care facilities and CC6 only involved community care organisations.

**Table 6** *Resources developed by leadership and change projects*

Project	Resources developed
CL1	Emerging Leaders training materials to run a series of six 1-day workshops for 'emerging leaders' in residential and community aged care. The target group are senior managers with a clinical background in residential and community aged care who can use the training materials to run the workshops.
CL2	Aged Care Clinical Mentor Model of Change: Six Steps to Better Practice, a guide which describes the six steps in the model of change for aged care clinical mentors. The guide is supported by various resources such as templates for action plans and activity reports, and a clinical mentor job description. The Aged Care Clinical Mentor Model of Change provides a means of identifying suitable clinical mentors and provides direction for clinical mentors to implement changes in their workplace. Resources developed by the action research projects to support new practices.
RC3	Better practice in aged care: A guide to the TOrCCh process for managers and workteam leaders. Better practice in aged care: A guide to the TOrCCh process for workteam members. These guides are supported by a series of templates and tools available on the website of the University of Western Australia's Centre for Health and Ageing. The TOrCCh Toolkit provides a guide for implementing the TOrCCh process without the need for external facilitation.
CC6	Valuing people: An organisational resource enabling a person-centred approach, an 'organisation improvement' resource which can be used by community organisations to assess how well their structures, systems and processes facilitate a person-centred approach and use the results to improve person-centredness. The resource has two components – a hard copy publication and tools available online to undertake organisational self-assessments (on the Alzheimer's Australia website). Valuing People Facilitator Manual

### 3.4.3 Enablers

The most important enabler for the four leadership and change projects was a receptive context for change; this has been described in different ways, but usually includes factors such as a need for change, a supportive culture which is conducive to innovation, managerial support, leadership, appropriate infrastructure and resources, and engagement of key stakeholders.<sup>17</sup> The importance of a 'receptive context' in residential aged care has been previously identified by our work in Round 1 and Round 2.<sup>18</sup> In the current program, one stakeholder described this as needing 'a fertile ground' (RC3\_1).

The nature of 'receptivity' varied across the projects. For the three action learning/action research projects the key elements were the support of managers, the commitment of those involved in the projects and the availability of sufficient resources (particularly time and funding) to participate in the project. The project sponsor in the RC3 project played a key role in facilitating a receptive environment.

In the clinical mentoring project, the personal characteristics of the clinical mentors had an important influence on the facilitation of teams and what they did. The clinical mentoring role was seen as being one of influencing others and building on what they knew already, rather than telling people what to do (CL2\_4). The evaluation of the clinical mentoring project identified seven attributes of an effective clinical mentor, including the ability to

<sup>17</sup> Dopson S, FitzGerald L et al. (2002) *No magic targets! Changing clinical practice to become more evidence based*. *Health Care Management Review*, 27 (3): 35-47.

Greenhalgh T, Robert G et al. (2004) *Diffusion of innovations in service organizations: systematic review and recommendations*. *Milbank Quarterly*, 82 (4): 581-629.

Pettigrew AM, Ferlie E and McKee L (1992) *Shaping strategic change*. SAGE Publications, London.

<sup>18</sup> Masso M, McCarthy G (2009) *Literature review to identify factors that support implementation of evidence-based practice in residential aged care*. *International Journal of Evidence-Based Health Care*, 7(2): 145-156.

provide leadership; relevant skills, expertise and experience; and the interpersonal and communication skills to work with their colleagues. Clinical mentors must be 'approachable' (CL2 Final Report, pp 30-31). One issue that arose during this project was the availability of the clinical mentors. The roles were funded two days per week, which meant two particular days allocated to the role. However, the need for mentoring is more likely to be episodic, as the need arises (CL2\_4).

There was some resistance to the projects but this tended to be limited and dissipated as staff came to see the benefits of what was taking place. One stakeholder (CL2\_5) referred to how staff had initially been resistant to the mentoring role but that this broke down once trust had been established (between mentor and mentees) and staff perceived the role to be beneficial.

The multi-disciplinary nature of the project teams in the CL1 project was seen as very important, underpinning the success of the project (CL1\_2). The teams 'broke down barriers between the direct care staff and those working behind the scenes' e.g. staff working in the catering or cleaning departments (CL1\_1). Participation in teams and the process of learning and working together to make changes can help to develop a sense of identity, where identity is a feeling of 'belonging and commitment'.<sup>19</sup> This sense of identity manifested itself as staff came to understand their role in the teams and the contribution they could make which was seen as 'validating' their own abilities, helping them to become more confident and engaged (CL1\_1) and 'grow personally' (CL1\_2).

#### 3.4.4 Barriers

The major barrier encountered by the leadership and change projects involved instances where the context within which they were operating was not receptive to change i.e. lack of management support, insufficient time and resources to support participation and lack of staff commitment. Three of the projects identified a problem with high staff turnover negatively impacting on what they were trying to do, primarily because of the constant need to educate new staff (CL2\_4, RC3\_3).

Comments by those involved in the RC3 project raised an interesting issue regarding applicability of the TOrCCh model. The model is meant to facilitate organisational change but stakeholders emphasised the need for certain things to be in place to 'help it happen' – leadership, management support, stability and the 'right people' involved – all of which are part of a receptive context for change. This suggests that the organisations that could benefit most from the TOrCCh model (because they need to change) are least likely to achieve success, because those organisations are not receptive to change taking place. As one of the interviewees said, 'There are some very important things that need to be in place before you can make culture change' (RC3\_10).

The main element of a receptive context for the CC6 project was the need to change in response to the move towards consumer direct care taking place in the aged care sector more broadly in response to federal government reforms. One stakeholder expressed this in terms of there being recognition that change needed to occur to prepare their organisation

<sup>19</sup> Handley K, Sturdy A et al. (2006) *Within and beyond communities of practice: making sense of learning through participation, identity and practice*. *Journal of Management Studies*, 43(3): 641-653.

for consumer directed care and that staff appreciated the importance of person-centred care. What was missing was a shared understanding of what was meant by consumer directed care and how it could be implemented in practice. The project provided the tools to assist their organisation to understand person-centred care and what needed to happen to make it a reality (CC6\_1).

### 3.4.5 Delays experienced

Any delays in the leadership and change projects were relatively short and largely occurred in the first 6-12 months with the withdrawal of participating services and the need to recruit replacements (three projects) and some difficulties recruiting and retaining staff. One project experienced a delay in gaining ethics approval (CL2). Two projects (CL2 and CC6) felt that the time frame for their project was too short.

## 3.5 Community care projects

As indicated previously in Figure 2 five of the projects implemented changes for clients living at home at the levels of clients, individual providers and the system within which they work. Details of the practice changes for each project, and the means of implementing those practice changes, are summarised in Table 7. It should be noted that the CC1 project effectively consisted of two sub-projects, one focusing on improving the management of leg ulcers, the other taking a more preventive approach by focusing on improving the awareness of clients about evidence-based skin care (a third sub-project – clinical leadership model - was also commenced, but not completed). The two sub-projects took a similar approach to implementation. All five projects placed a strong emphasis on training staff, with some education of clients and the use of additional ‘system-level’ strategies such as the use of care plans and assessment tools.

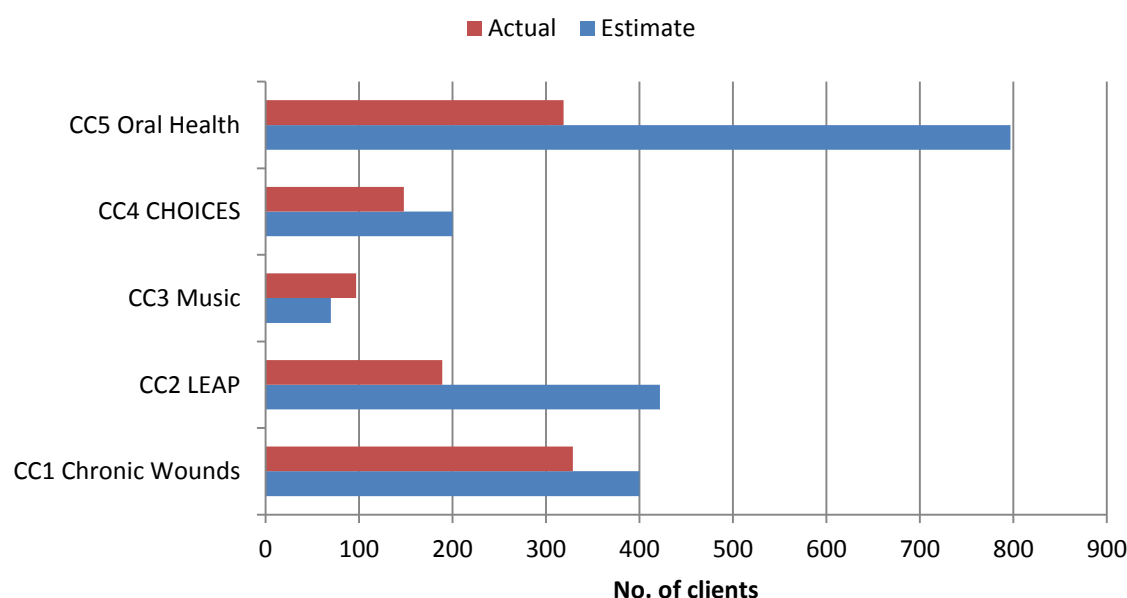
**Table 7** *Implementation strategies and practice changes, community projects*

Implementation strategies	Practice changes
<b>CC1</b>	
Funding to cover the cost of staff training. Establishment of LUPP teams (of nurses) at each implementation site. Education of nurses to use Leg Ulcer Prevention Program (LUPP). Workshops on clinical leadership for team leaders (LUPP project). Education of clients using the LUPP package (six sessions), primarily by using a portable DVD player. Provision of LUPP kit to clients (containing DVD, book, drink bottle, tape measure, skin care samples, two sets of four layer compression bandages and a leg protector). Education of community care aids to use Skin Awareness Program (SAP). Education of clients using the SAP e-learning package. Provision of SAP kit to clients (containing DVD, book, skin care products and first aid packs) Assessment of skin risk and use of skin inspection progress record. Clinical Leadership Group, including local champions, to provide clinical leadership for evidence-based wound management.	Interventions by nurses and clients to improve wound management e.g. compression bandaging for leg ulcers. Interventions by community care aids and clients to improve prevention of pressure ulcers e.g. checking skin, use of skin care products.
<b>CC2</b>	
Train care workers to include interventions in usual care. Include interventions in client care plans. Train case managers to include interventions in client care plans. LEAP champions at each implementation site to support case managers. Train LEAP champions.	Interventions by care workers to promote client activity.

Implementation strategies	Practice changes
<b>CC3</b>	
Training of care workers and case managers by a music therapist. Education of care workers and case managers on the physical and psychological changes of elderly people. Education of clients and family members (about dementia and memory loss).	Play client's favourite music for about 30 minutes while personal and home care services are being provided in the client's home.
<b>CC4</b>	
Training of case managers, personal carers and other members of the aged care workforce. Use of client assessment and care planning tools. Mentoring and support of case managers. Client forums to provide information to clients to assist them in understanding the activities required for higher levels of self-direction.	No specific interventions. The aim is to increase client involvement in decision-making about their own care.
<b>CC5</b>	
Training of community aged care staff in oral health care, oral health assessment and care planning. Provision of oral health self-care booklet and bathroom prompts to clients. Use of 6-question oral health assessment tool. Use of oral health care plans. Referrals to dentists for dental examination and treatment.	Interventions by care workers and clients to improve daily oral hygiene e.g. use of fluoride toothpaste, brushing teeth regularly, relieving dry mouth,

For these five projects, one measure of the degree to which implementation took place is the number of clients who potentially benefitted. Figure 3 shows the number of community clients estimated to be assisted by each project (in the application for project funding) and the actual number of client assisted by each project. Four projects fell short of their target for number of clients and one project (CC3) exceeded its target.

**Figure 3** Number of clients involved in each community project



Each project developed training resources targeting providers and three projects (CC1, CC3 and CC5) developed resources for consumers (Table 8).



**Table 8** *Resources developed by community projects*

Project	Resources developed
CC1	Leg Ulcer Prevention Program client education program (e-learning package with hard copy handbook), modified from a previously developed package. Leg Ulcer Prevention Program nurse training package (hard copy). SAP client education program (e-learning package with hard copy handbook). SAP health worker and nurse training package (hard copy)
CC2	Six training manuals to facilitate the training of case managers, LEAP champions and care workers (four manuals), with associated booklets. <i>A Guide for the Trainer</i> , including overview of LEAP and recommended reading list. Five short videos to support the LEAP program.
CC3	A guide book for clients, families and home care workers about the program. The other resources developed by this project were for individual clients e.g. CDs and song books.
CC4	9 web-based training modules <sup>20</sup> , each covering a separate topic (e.g. CHOICES overview, the concept of restorative health and capacity building, goal directed care planning, self-direction and mentoring) Many of the resources that support the delivery of the CHOICES model were modified for three different audiences (CALD, rural regional and ATSI).
CC5	<i>Better Oral Health in Home Care Resource</i> – can be used online or in hard copy as a self-directed learning resource, or as the basis for staff training sessions. <i>Better Oral Health in Home Care Facilitator Guide</i> – to be used by facilitators to support staff training. Audio-visual resources for health care workers. Oral health self-care booklet and bathroom prompts (for clients).

The small-scale nature of the practice changes typically made by each project makes it difficult to judge the degree to which those changes were implemented. The CC1 Chronic Wounds project produced good data demonstrating that the use of evidence had improved. Three projects (CC2, CC3 and CC4) effectively produced no data to support an increase in the use of evidence-based practices (Table 9).

**Table 9** *Impact on use of evidence, community projects*

Project	Impact on use of evidence
CC1	Clients with leg ulcers had their wounds assessed in accordance with evidence-based practice. The 'gold standard' for the management of leg ulcers is the use of compression bandaging. The results of the project-level evaluation did not show any increase in the compression strength being used on clients participating in the project. There was some evidence that clients increased their intake of supplements and multivitamins, and increased their leg activities (to promote leg circulation). There was no change in smoking behaviour by clients. There were increases in appropriate skin care by clients e.g. use of soap-free cleansers, use of moisturisers, and daily examination of legs for skin damage.
CC2	The project final report does not include any data regarding the use of evidence, other than to state that 12 months after project commencement '87% and 76% of clients had a social or recreational goal and/or an engagement strategy in their care plans, respectively; and 54% has a personal history sheet in their care plan'. There is no data about care planning or personal history taking prior to project commencement. There is no data included in the report about changes in social or recreational activities by clients.
CC3	The project final report states that the project 'facilitated clients to establish a routine habit of listening to their preferred music' but no data is included in the report to back up this claim.
CC4	There is some evidence that participating organisations have incorporated key elements from CHOICES

<sup>20</sup> <http://www.choicesinagedcare.com.au/training/>







Project	Impact on use of evidence
	practice tools into their updated CDC paperwork, and it is reported that some Case Managers had expanded their professional knowledge and experience as a result of their participation in the project.
CC5	Oral health assessments were undertaken on clients enrolled in the project. There is no evidence in the project final report regarding oral health care planning and changes in oral health care practices. Clients were referred to dentists. In the project final report it is argued that because oral health outcomes improved for clients that this can be taken as evidence that the evidence-based practices incorporated in the Better Oral Health in Home Care Model were being used i.e. it is assumed that the use of evidence increased because outcomes increased.

### 3.5.1 Enablers and barriers

In previous progress reports by the evaluation team we identified various enablers and barriers to implementation, based on site visits and the progress reports from each project. Analysis of project final reports and our own stakeholder interviews highlighted the pivotal role played by clients when implementing change within community aged care. Table 10 summarises the findings from this analysis, in the form of the main factors influencing implementation of practice change in home-based care across the five projects.

**Table 10** *Main factors influencing implementation, community care projects*

Level	Factors influencing implementation		
Consumers	Characteristics of clients – e.g. language abilities, culture, motivation, confidence, cognitive ability.	 Engaging clients 	 Reconciling competing priorities 
Providers	Establishing a common ground for change. Seeing the benefits of change.		
System	Support from managers, peers or someone in a designated position such as a champion.		

### Engaging with clients

A recently published study involving people with dementia living at home, carers, service providers and policy makers identified the preferred characteristics of a person-centred service. For example, personalising activities to the needs of clients; socialisation (of the client) outside their home; having staff with desirable attributes (e.g. caring, understanding, a sense of humour); treating clients with respect; engaging clients, carers and extended family in the clients' care; and having staff with the ability to engage with clients.<sup>21</sup> The aims of the five community projects were consistent with these preferred characteristics, with one project aiming to increase client involvement in decision making (CC4), two projects having a strong emphasis on client self-management (CC1 and CC5), one project promoting psychosocial activities for clients (CC2) and one using music to improve client mood and reduce carer stress (CC3).

<sup>21</sup> Low L-F, White F, et al. (2012) *Desired characteristics and outcomes of community care services for persons with dementia: What is important according to clients, service providers and policy?* *Australasian Journal on Ageing*, 32(2): 91–96.

At the core of a person-centred approach is the ability of staff to engage with clients and carers and each project included multiple opportunities for engaging with clients in new ways:

- The leg ulcer component of the CC1 project involved educating clients about venous leg ulcers. Although education was already provided to clients, the project enabled a more consistent approach to education and prompted greater interaction between staff and clients.
- The skin awareness component of the CC1 project involved staff educating clients with the assistance of an e-learning package.
- The CC2 project aimed to include social and recreational activities into client care, which necessitated not only discussions between staff and clients about such activities, but interaction between staff and clients during some of the social and recreational activities.
- The CC3 project involved discussions between staff and clients on clients' music preferences; and clients, carers and staff sharing the experience of listening to music.
- The CC4 project promoted discussions between staff and clients on issues such as client goals for care.
- The CC5 project had a strong component of client education and the use of an oral health assessment tool, all of which required interaction between staff and clients.

In one project there was the perception that the client education package helped to 'break down barriers' between staff and clients and 'start a dialogue' (CC2\_4). In another, the nature of the project (setting client goals) prompted conversations with clients (CC4\_5). The final report of one project noted that for some staff, the leg ulcer prevention program 'facilitated dialogue/partnership between client and nurse and enabled questions in a relaxed setting' (CC1 final report, p 55).

Not surprisingly, therefore, the ability to engage with clients was an important enabler of implementation, usually in the form of conversations between staff and clients. One of the people we interviewed commented that the project they were involved in provided an opportunity for 'positive dialogue' with clients, which was appreciated by both staff and clients (CC1\_8). Another referred to clients being more talkative, with the playing of music evoking memories and promoting conversations between staff and clients (CC3\_1). In the view of one stakeholder, engaging with clients was a more successful aspect of their project than what the project was actually trying to achieve (greater involvement of clients in social and recreational activities) (CC2\_5).

### Client characteristics

The stakeholder interviews also identified various barriers to client engagement, primarily influenced by the characteristics of clients rather than the characteristics of staff:

- Clients who are cognitively impaired, particularly if the aim is to improve client self-management (CC1\_1, CC1\_5).
- If education sessions are too long, then clients' concentration starts to wane (CC1\_5).
- The 10-week client education program on skin awareness was found to be too long for many clients, because of their age and multiple health issues (CC1 final report).

- Cultural differences between staff and clients (CC2\_1 and CC2\_6).
- Differences between client goals (to have a clean house) and project goals (social and recreational activities) (CC2\_3, CC2\_6, CC4\_5). Many of these differences had a cultural basis e.g. one stakeholder expressed the view that elderly people from a Greek background find it hard to talk about goals (CC4\_5).
- Ability of clients to comprehend the written or spoken word e.g. clients from culturally and linguistically diverse backgrounds (CC2\_4 and CC4\_2).

The CCI Chronic Wounds final report identified several client characteristics that influenced the ability of nurses and clients to engage with one another e.g. knowledge, physical and mental capabilities, motivation.

### A common ground for change

There was little evidence of overt resistance from managers or staff to the practice changes. More typically, there was a lack of enthusiasm in some quarters but this was usually due to a lack of understanding of the proposed changes. One interviewee described how staff were 'quite oppositional' in the first instance because they 'couldn't get their heads around' the proposed changes (CC4\_6). This could be rectified by education, advice from a colleague or working together in a team (and hence learning from others). In one instance this was described as care workers being 'a bit reluctant at first', in which case the project team used education to assure the care workers that the project was 'straightforward' (CC3\_3).

Stakeholders generally referred to what needed to happen in these situations in terms of achieving greater understanding: understanding the evidence supporting the practice changes (CC1\_2); 'understanding the concepts' (CC4\_9); understanding what needs to change and how to make that happen in practice (CC1\_7); and understanding how the practice change was 'connected' to the needs of the client (CC5\_2). What was important was to arrive at a situation where there was a 'common understanding' (CC3\_3), where people were 'on the same page' (CC4\_6, CC5\_2) or 'on board' (CC4\_9). These findings are consistent with research undertaken in Round 1 and Round 2 which identified a 'common ground for change' as the key enabler of implementing evidence-based practice in residential aged care.<sup>22</sup> One stakeholder commented that achieving a sense of common ground 'glues everyone together' (CC3\_3).

### Seeing the benefits of changes

There is some evidence in the literature that if the benefits of a new practice are 'observable'<sup>23</sup> or 'visible'<sup>24</sup> then the new practice will be adopted more readily. Such benefits have also been described as 'demonstrable'.<sup>25</sup> In Round 1 and Round 2, instances of staff 'seeing the benefits' for residents acted as positive reinforcement that actions were

<sup>22</sup> Masso M, McCarthy G, Kitson A (2014) *Mechanisms which help explain implementation of evidence-based practice in residential aged care facilities: A grounded theory study*. *International Journal of Nursing Studies*, 51(7): 1014-1026.

<sup>23</sup> Berta W, Teare GF et al. (2005) *The contingencies of organizational learning in long-term care: factors that affect innovation adoption*. *Health Care Management Review*, 30(4): 282-292.

<sup>24</sup> Greenhalgh T, Robert G et al. (2004) *Diffusion of innovations in service organizations: systematic review and recommendations*. *Milbank Quarterly*, 82(4): 581-629.

<sup>25</sup> Masso M, McCarthy G (2009) *Literature review to identify factors that support implementation of evidence-based practice in residential aged care*. *International Journal of Evidence-Based Health Care*, 7(2): 145-156.

appropriate, establishing a link between actions and outcomes.<sup>26</sup> In the community projects, there were similar examples of how being able to 'see the benefits' enabled change to occur. In the chronic wounds project, staff were able to see that their clients were becoming more proactive in their skin care, identifying skin problems before they got worse (CC1\_3). This was recognised in the final report from that project:

*Because of the increased understanding of the skin of older people, and how small problems can develop into bigger problems if not addressed, health workers began to recognise the significant contribution they can make to their clients' health and wellbeing. (CC1 final report, p 140)*

In the CC2 project, staff were able to see clients pursuing activities that they would not ordinarily attempt due to cognitive or physical deficit (CC2\_1). One stakeholder in the music project referred to how playing music evoked memories for clients and promoted conversation between clients and aged care workers. This was not only good for clients, but it was also good for workers 'dealing with happy clients' (CC3\_1). Another interviewee said that once care workers see the positive impact on their clients it 'changes their mindset' (CC3\_3). With the CC4 project, which aimed to increase client involvement in decision-making about their own care, the benefits manifested in clients taking more control over their own affairs, a change described as 'tangible' (CC4\_6). One stakeholder described how clients taking charge of their own affairs was 'a real enabler – to see it in practice is amazing' (CC4\_6).

### **Support from managers, peers or someone in a designated position**

In Round 1 and Round 2 of the program, which took place in residential aged care, stakeholders identified the importance of having people at all levels of the organisation providing leadership for implementation of evidence-based practice. In the five community-based projects in the current program with a focus on implementing evidence-based practice, stakeholders also spoke about the need for individuals occupying particular positions (e.g. champion, case manager) to 'drive change' (CC1\_7, CC2\_3, CC4\_2).

More generally, however, stakeholders spoke about the need for 'support' rather than 'leadership'. It was important that support for frontline staff came from somewhere; from their manager, their peers or someone in a designated position such as a champion or mentor. Where it came from was not as important as the fact that it came from somewhere. The presence of support helped implementation and the absence of support hindered implementation. In one project this support was expressed in terms of providing mentorship and guidance (CC4\_6), whereas in another project this was framed in terms of providing coaching (CC1\_7). In other instances, 'support' was expressed in terms of support from management, illustrated by the final report from one project which drew the link between management support and changing staff behaviour:

*When care staff could see tangible evidence of management supporting the project that they were much more likely to change their own behaviour. (CC2 final report, p 14)*

<sup>26</sup> Masso M (2012) *It's the little things that matter: implementation of evidence-based practice in residential aged care*. Doctor of Philosophy thesis, University of Wollongong, Wollongong, NSW, Australia.

Feeling supported is one aspect of what is known as collective agency i.e. people working together to implement changes in practice. The key ingredient of collective agency has been described as ‘peoples’ shared belief in their collective power to produce desired results’.<sup>27</sup>

### Reconciling competing priorities

Stakeholders described a situation where the system of care delivery involved many competing priorities:

- The additional cost of implementing a new practice (e.g. the cost of wound care) versus the potential benefit of the new practice (CC1).
- Allocating time for client education (and potentially empowering clients to manage some aspects of their own care) versus spending time completing tasks (CC1\_1).
- The priority assigned to ‘doing’ versus the priority assigned to thinking, reflecting and taking a more holistic approach. This was described by the CC5 project as a ‘task and time’ approach versus a ‘think and link’ approach.
- Some aspects of care considered more important than others – some work must be done (CC2\_4).
- The priority given to prevention (e.g. skin care, oral health care) versus the priority given to other tasks (CC1, CC5).
- Different priorities of staff and clients (CC2\_2, CC2\_3).
- The priority assigned to introducing something new versus the priority assigned to what is being done currently (CC2\_5, CC4\_7).
- Doing the best for the client versus doing what is feasible financially (CC4\_7).

Many stakeholders spoke about the lack of resources in some way, typically in the form of there not being enough time to do what needs to be done for clients: ‘really, it is all about resources: time, for the most part’ (CC1\_7). Time spent by staff with clients on each home visit is limited with ‘lots of things to do’ (CC2\_4). Introducing something new thus presented challenges in terms of ‘fitting’ that into existing routines and practices.

This resulted in various strategies for reconciling these competing priorities. For example:

- Ensuring that client education was succinct (and hence less time-consuming) and meeting the needs of clients (CC1\_5).
- Negotiating with clients to resolve competing priorities and introduce something new (e.g. recreational activities rather than cleaning the client’s house) (CC2\_2).
- Trying out another way of doing things if the first way did not work (CC2\_4).
- Encouraging clients to maintain a simple routine for looking after their own care (e.g. oral health care); or, in the case of the CC3 project, establishing a routine habit of clients listening to their preferred music.

Another strategy was to work out a way of essentially doing two things at the same time, as illustrated by this comment from the LEAP project:

<sup>27</sup> Bandura A (2001) Social cognitive theory: an agentic perspective. Annual Review of Psychology, 52: 14.

*We knew that time and money were our big challenges. We purposefully trained care staff on using engagement strategies that could be incorporated as part of other care tasks. For example, reminiscing with a client whilst you drive to the doctors' appointment, playing music whilst you do the housework, using objects around the house for a Montessori activity, assisting with setting up leisure interests that the client can pursue outside of care worker hours, and so on. (CC2 final report, p 13)*

Much of this reconciling of competing priorities took place in one-to-one interactions between individual staff and individual clients, within the context of the organisational system of care i.e. the processes, structures, systems and resources which support care in the home, including the use of new assessment tools (CC1, CC4 and CC5), care plans (CC2, CC4 and CC5) and referral pathways (CC5).

### 3.5.2 Delays experienced

The community projects experienced some delays, but nothing that would be considered unusual in a program of this nature (see Table 11). Two projects reported difficulties recruiting sufficient clients (CC1 and CC4).

**Table 11** *Delays to implementation, community projects*

Project abbreviation	Delays in implementation and reasons for those delays
CC1	One major provider withdrew from the project, which had a major impact given that many staff and clients of that provider had already been recruited to the project. The replacement provider (a hospital outpatient clinic) did not fit well with the focus of the project (providing care in clients' homes). There were ongoing difficulties recruiting clients to the project. Gaining ethics approval was time consuming because of the multiple sites involved in the project.
CC2	Considerable difficulties were experienced recruiting a Vietnamese-speaking project assistant. Some delays in developing training materials. One provider withdrew from the project and had to be replaced.
CC3	Minor delays in recruiting project participants during the first six months. Producing the resources for clients (CDs and song books) was time consuming and resulted in delays to implementation.
CC4	Developing project resources took longer than anticipated, although this did not adversely impact on the project.
CC5	The project proceeded on schedule.

### 3.6 National roll-out projects

Both national roll-out projects built on work that was carried out in Round 2: the *Implementation of a comprehensive evidence based palliative approach in residential aged care (CEBPAC)* project and the *Creating champions for skin integrity* project. This included updating and refining the resources developed in Round 2.

Each national roll-out project focused on actively disseminating the resources by running workshops across the country, but with a slightly different approach. One primarily ran workshops for people about the *Palliative Approach Toolkit*, whereas the other project (RC2) ran train-the-trainer workshops for people who had been identified by their facilities as skin integrity champions, with the intention that those people would then return to their facilities to train other people as part of their role. Those attending the RC2 workshops were requested to develop a plan to implement the CSI model in their own facility and send a 1-

page report on progress with implementation three months after the workshop. There was no such post-workshop activity with the palliative care workshops.

The two projects ran a similar number of workshops, with a similar distribution across the country according to level of remoteness. In response to strong demand, the Department funded additional CSI workshops in regional areas. Each project achieved their target for number of workshops by project end.

The RC1 project trained 1,995 people from 1316 facilities; the RC2 project trained 1286 people from 835 facilities. The distribution of residential aged care facilities represented at the workshops was similar for each project and reflected the distribution of facilities across the country (Table 12).

**Table 12** *Location of workshops and facilities represented at workshops, national roll-out projects*

	Location of workshops				Location of facilities represented at workshops		
Remoteness category	RC1		RC2		RC1	RC2	Distribution of facilities in Australia
	No. of workshops	% of total	No. of workshops	% of total	% of total	% of total	
Major cities	20	56%	23	62%	67%	64%	61%
Inner Regional	12	33%	11	30%	24%	22%	25%
Outer Regional	3	8%	3	8%	8%	13%	12%
Remote/very remote	1	3%	0	0%	1%	1%	2%
<b>Total</b>	<b>36</b>	<b>100%</b>	<b>37</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Note: the distribution by remoteness category for the RC1 project is based on data for all workshops; for the RC2 project it is based on data from the first 15 workshops.

The RC1 project adapted their training resources to meet local needs. In Victoria, this involved half-day train-the-trainer workshops for the North and West Metropolitan Palliative Care Consortium. In Western Australia, the workshop material was adapted for a half-day 'update' workshop targeted at staff that had previously received training in the *Palliative Approach Toolkit*.

In addition to the workshops, hard copies of the resources – the *Palliative Approach Toolkit* and the *Champions for Skin Integrity Guide and Resource Pack* – were distributed nationally to residential aged care facilities and each project undertook activities to market the resources (e.g. conference presentations, articles in industry newsletters). The RC1 project was able to host its resources on the CareSearch website, the central repository for



palliative care resources in Australia<sup>28</sup>. The RC2 project resources are available on the Queensland University of Technology website<sup>29</sup>.

Neither project was directly responsible for changing practices in facilities; rather, any practice changes arising from these projects were determined by those attending the workshops and other staff in their facilities. Practice changes implemented by facilities were an indication of the impact of the workshops (see Appendix 4 and 5).

Both projects experienced delays in producing their respective resources but in only one case (RC1) was this significant (six months). The RC2 project took a couple of months longer than anticipated to conduct an evidence review of their resources but were able to make up this delay with improvements to the scheduling of workshops. Both projects experienced higher than expected costs for running workshops, either because of the high costs of venue hire (RC2) or the larger than expected number of attendees, resulting in the need for greater administrative support for the workshops (RC1).

The results of a survey of workshop participants conducted for the program evaluation were remarkably similar for both projects, with a very high proportion of participants rating the workshops as either meeting or exceeding their expectations; agreeing that the materials and small group activities used during the workshops assisted their learning; and rating the length of the workshop as 'about right'. Almost all participants would recommend the workshops to their colleagues and saw the workshops as a preferred mode of delivery for this type of education (Table 13).

**Table 13** Responses to survey of participants, national roll-out projects

Question or statement	Response to question or statement	% of respondents	
		RC1	RC2
Please rate the workshop in terms of meeting your expectations	Met, exceeded or greatly exceeded my expectations	99%	97%
The PowerPoint slides, handouts and other resources used during the workshop assisted my learning	Agree or strongly agree	95%	95%
The length of the workshop was	'About right'	89%	91%
Is attending a workshop your preferred mode of delivery for this type of education?	Yes	97%	97%
Would you recommend the workshop to a colleague?	Yes	98%	98%
Did the small group activities used in the workshop support your learning?	Yes	94%	93%

Participants believed that the resources that formed the basis of both sets of workshops (the *Palliative Approach Toolkit* and the *Champions for Skin Integrity Guide and Resource Pack*) were the most valuable aspect of the workshops (Table 14). The opportunity to network with colleagues at the workshops was also much appreciated. Further details

<sup>28</sup> <http://www.caresearch.com.au/CareSearch/tabid/2718/Default.aspx>

<sup>29</sup> <https://www.qut.edu.au/research/research-projects/wound-care-in-residential-aged-care-facilities-national-dissemination>



regarding the results of the survey of workshop participants can be found in Appendix 4 and 5.

**Table 14** *Resources developed by the national roll-out projects*

Project	Resources developed
RC1	<p><i>Palliative Approach Toolkit</i>, available on the CareSearch website. The Toolkit includes a comprehensive range of resources: workplace implementation guide, training support guide, clinical guidelines, three learning modules, four self-directed learning packages, three DVDs, flipcharts, information brochures and various clinical tools and forms.</p> <p>Training materials to support two workshops: one to train workshop trainers, the other to run half-day 'update' workshops (much of the activity of this project was to run 1-day workshops about the Toolkit, the training materials for which had been previously developed as part of the EBPRAC program).</p>
RC2	<p><i>Champions for Skin Integrity Guide and Resource Pack</i>, a resource package for those who want to become a Champion for Skin Integrity (CSI), available in hard copy or online, supported by a CSI Resource CD which includes a copy of all the material and a training package about the use the accompanying data collection tools. The CIS Guide and Resource Pack includes eight clinical guideline summaries (e.g. skin care, wound care, nutrition and wound healing) and short 'tip sheets' for clients and carers, each including a list of simple 'dos and don'ts'.</p> <p>Training resources to run 1-day train-the-trainer workshops for skin integrity champions.</p>

### 3.7 Comparison with Round 1 and Round 2

All projects in Round 1 and Round 2 focused on one thing – implementing evidence-based practice in residential aged care. In the current program, the mix of projects was more diverse, in terms of setting (residential and community care); emphasis (changing practices, training clinical leaders, developing resources to facilitate organisational change, nation-wide dissemination) and evidence base (in Round 1 and Round 2, there was a strong focus on implementing evidence-based clinical guidelines whereas in Round 1 and Round 2 there was a greater emphasis on building on what had been learnt or developed in previous projects).

There was much less data supporting an increase in the use of evidence in the current program than there was in either Round 1 or Round 2. Factors influencing the implementation of evidence based practice included establishing a common ground for change; seeing the benefits of change; support from managers, peers or someone in a designated position; and the ability to reconcile competing priorities in an environment of limited resources, all of which were found in Round 1 and Round 2. The main difference between the current round and the previous rounds (in terms of implementing evidence) was the pivotal role played by clients in whether evidence-based changes took place. The ability of staff to engage with clients was also a critical determinant of whether change took place or not, another difference compared to the earlier rounds.

## 4 PROJECT IMPACT

As mentioned previously, the EBPAC program includes a diverse mix of projects, employing different methodologies to achieve a wide range of outcomes. In relation to the three levels of our evaluation framework (consumers, providers, system), each project can be categorised into those focusing at one 'level' and those working across all three levels as previously illustrated in Figure 2. To report on project impact we have again grouped the projects according to their main focus:

- The four system-level projects which sought to develop models for training clinical leaders (CL2 and CC6) and facilitating organisational change (RC3 and CL1 ).
- The five projects which aimed to implement evidence-based practice in community care (CC1, CC2, CC3, CC4 and CC5).
- The two projects which primarily ran nation-wide workshops to disseminate current evidence in the areas of palliative care and skin care (RC1 and RC2).

This section provides a summary of project impacts at the consumer, provider and system level. Further details about individual projects are provided in the project summaries included in Appendix 1.

### 4.1 Impact and outcomes on consumers

Many of the EBPAC projects incorporated practice changes targeted at consumers. Four projects did not include any practice changes in their project plan targeted specifically at consumers. However, two of these (CL2 and RC2) were able to demonstrate positive outcomes on consumers.

#### 4.1.1 Consumer impacts and outcomes: Leadership and change projects

Table 15 summarises the practice changes targeted at consumers for the leadership and organisational change projects. The outcomes reported in this table are synthesised from information reported by projects in their final reports, rather than reflecting the findings of the evaluators.

**Table 15** Consumer impacts and outcomes: Leadership and change projects

Project	Practice changes	Outcomes on consumers
CL1	Small-scale changes in each facility, as determined by each action learning team.	The project did not measure specific client outcomes
CL2	No direct implementation strategies targeted at clients	Qualitative comments from residents/clients reveal satisfaction with the changes in care services.  Satisfaction surveys with both residents and clients showed no real changes in resident satisfaction but a significant increase in satisfaction with care services in the community
CC6	Nil (project limited to development and distribution of the resources)	N/A
RC3	Small-scale changes in each facility, as determined by the TORCCh team.	The project did not measure specific client outcomes

For two of the leadership and change projects, the emphasis was on using project resources to initiate organisational change projects within aged care facilities. The RC3 project specifically targeted consumers in a walking program, a gardening program and the implementation of a palliative care trolley. In the case of CL1 the project targeted consumers including a focus on palliative care pathways, oral hydration, oral hygiene and falls prevention.

Neither of these projects measured client outcomes as part of their evaluation strategy. However, the key stakeholder interviews held with residential aged care managers suggested some positive outcomes for residents. For example the manager at an aged care facility in Western Australia reported receiving regular positive feedback from family/carers about the palliative care trolley (RC3). Another manager whose facility hosted a walking and gardening program commented that residents loved these two initiatives (RC3). He commented that prior to these two initiatives residents would 'often isolate themselves in their rooms'. However, the residents slowly embraced the walking and gardening projects and as a result made new social connections and also improved their mobility at the same time.

A second leadership and change project (CL2) did not have any direct implementation strategies targeted at clients as part of their project plan. Rather, clinical mentors were trained to deliver specific workforce solutions in their facility or in community aged care. Projects included a focus on manual handling, wound management, pain management and managing dementia. An independent evaluation was carried out by Flinders University but evaluation results relating to consumers were mixed. A resident satisfaction survey revealed no significant change in satisfaction in facilities whilst a similar satisfaction survey carried out with community clients showed a significant increase in satisfaction with the care services they received.

The fourth leadership and change project (CC6) did not explicitly seek to impact directly on clients and therefore did not include any impact on consumers in their final report. The project did, however, include consumer input into the development of the methodology and resources developed by the project.

#### 4.1.2 Consumer impacts and outcomes: Community care projects

Five of the six community care projects included practice changes targeted at consumers but the nature of change in practice was variable. These practice changes together with reported outcomes are highlighted in Table 16.

**Table 16** *Consumer impacts and outcomes: Community care projects*

Practice changes	Outcomes on consumers
CC1	
Interventions by nurses and clients to improve wound management e.g. compression bandaging for leg ulcers. Interventions by community care aids and clients to improve prevention of pressure ulcers e.g. checking skin, use of skin care products	It is reported that both LUPP and SAP led to an increase in client knowledge of leg ulcers and skin health and the adoption of some of the recommended wound management behaviours
CC2	

Practice changes	Outcomes on consumers
Interventions by care workers to promote client activity	Clients showed an increase in researcher-rated engagement, and a decrease in researcher-rated apathy, dysphoria and agitation
CC3	
Play client's favourite music for about 30 minutes while personal and home care services are being provided in the client's home	Clients' feedback revealed that they have re-found their love for music. The Mood Change analysis demonstrated that approximately 85% of participants experienced mood improvements as a result of the music intervention.
CC4	
The aim is to increase client involvement in decision-making about their own care.	The quantitative data suggests that the CHOICES model had a statistically significant effect on the perceived quality of case management. Overall, clients felt more respected, informed, and appreciated the new financial arrangements.
CC5	
Interventions by care workers and clients to improve daily oral hygiene e.g. use of fluoride toothpaste, brushing teeth regularly, relieving dry mouth,	The project demonstrated positive improvements in home care clients' oral health related quality of life and wellbeing. Clients also felt more confident in their own efforts to improve their oral health.

Two of the projects (CC1 and CC5) both provided consumers with education and support for wound care and oral health. Another two (CC2 and CC4) provided information to consumers to promote physical activity and to introduce the concept of consumer directed care. The fifth project (CC3), trialled the use of music to complement existing home care services.

Four of the community projects (CC1, CC2, CC3 and CC5) involved specific interventions carried out by care workers. Each of these projects specifically measured consumer outcomes as part of their evaluation strategy. Project CC1, demonstrated an increase in client knowledge and management of chronic wounds. Four out of the five care workers interviewed by the evaluation also indicated that their clients were more proactive in managing their skin even after the project was completed. However, one care worker indicated that the project was not appropriate for use with clients with cognitive impairment, e.g. clients with dementia.

The CC2 project aimed to increase clients' physical activity. The project evaluation methodology included semi-structured interviews with case managers and LEAP champions, questionnaires completed by care workers, and questionnaires and interviews with clients and family members. Whilst the evaluation results as presented in the projects final report were very general in nature, they did highlight an increase in client engagement. Interviews carried out by the evaluation team with care workers did not elicit any positive client outcomes.

The CC3 project focussed on music therapy. The project evaluation was able to show that client's mood status increased as a result of the music intervention. A member of the evaluation team held a focus group with 13 care workers and their care managers. During

this focus group several examples of positive client experiences were mentioned. Clients were described as 'more talkative', 'happy' and in one specific example the music intervention 'took away the clients headaches'.

The CC5 project aimed to improve clients' oral hygiene through interventions by care workers and the provision of relevant oral health resources. A detailed evaluation carried out by the project team demonstrated numerous benefits to clients. Overall the evaluation demonstrated positive improvements in clients' oral health related quality of life and wellbeing and increased confidence in managing their own oral health. This was confirmed in care worker interviews carried out by the evaluation team. In one instance a care worker commented that:

*One gentleman did say to me that he felt he could smile without holding his hand over his mouth; it definitely improved his quality of life.(CC5\_2)*

#### 4.1.3 Consumer impacts and outcomes: National roll-out projects

Table 17 summarises the practice changes targeted at consumers for the national roll-out projects.

**Table 17 Consumer impacts and Outcomes: National roll-out projects**

Practice changes	Outcomes on consumers
RC1	
No direct implementation strategies targeted at residents	After death audits reveal that more residents commenced an end of life pathway
RC2	
No direct implementation strategies targeted at residents	Evaluation reports received from facilities demonstrated positive resident outcomes such as reduced prevalence of skin tears and wounds and improved skin integrity.

Little data was collected by RC1 relating to patient outcomes. The only reference to resident outcomes in the pre-implementation and post-implementation After Death Audit relates to length of hospital stay. The project final report indicates that there is no statistically significant difference between length of hospital stay between the pre and post audit.

Measuring impacts and outcomes on residents was also not included in the project evaluation plan for RC2. However, data relating to aged care clients, families or carers is implicitly included in many of the workshop participants' project plan reports. According to the final report:

*Overwhelmingly plans reported great improvements in skin integrity and reduction in the development of skin tears and pressure ulcers as a benefit to the aged care clients. When these did occur reported healing rates were shown to have improved a great deal compared to previous data (RC2 final report, p.22).*

The most frequently reported CSI Project client and family outcomes in the 176 reports received include:

- Reduced prevalence of skin tears - 32%
- Improved skin integrity - 26%

- Reduced prevalence of wounds - 18%
- Increased implementation of skin moisturising - 18%
- Reduced prevalence of pressure injuries - 13%
- Shorter times to healing - 14%
- Improved resident comfort - 8%

No data was able to be extracted from the surveys with workshop participants or the interviews with key stakeholders relating to resident outcomes.

Whilst four projects did not include any practice changes in their project plan targeted specifically at consumers, two were able to demonstrate positive outcomes on consumers (CL2 and RC2).

Overall, despite a mixture in the quality of the evaluation methods, the four community projects with specific interventions carried out by care workers produced the best evidence that consumer outcomes improved. Two of these, with a strong focus on prevention (CC1 and CC5), were able to provide the most comprehensive evidence that consumer outcomes improved following the provision of education and support.

## 4.2 Impact and outcomes on providers

Given that all projects were designed to directly influence providers' delivery of evidence based practice, there is significant data provided to identify the extent of the impact and outcomes on this group.

### 4.2.1 Provider impacts and outcomes: Leadership and change projects

Table 18 highlights the various implementation strategies specifically targeted at providers by the leadership and change projects. Again, the relevant outcomes are those reported by projects in their final reports.

**Table 18** *Provider impacts and outcomes: Leadership and change projects*

Implementation strategies	Outcomes on providers
CL1	
Funding to cover the cost of staff training. Mentors to support action learning teams. Training program for mentors. Multidisciplinary teams in each facility to undertake an action learning project in a clinical area of choice. Six one-day leadership workshops for team members. Additional strategies in each facility as chosen by action learning teams.	Participants learned new skills, new respect for one another's expertise and capabilities, revitalised their knowledge of current evidence for care practices and developed attributes of a high performer. Participants felt the program instilled a sense of self-belief, self-confidence and competence to make changes in the workplace, improved their ability to work in interdisciplinary teams, and identify ways to make changes in the workplace. It is also reported that it made work more meaningful.
CL2	
Funding for clinical mentors appointed (2 days/week) and champions (1 day/week). Clinical mentors in each facility or community service. Champions to support the clinical mentors (funded one day per week).	Participants described improved competence and confidence as a result of the education/training activities. Staff developed their own leadership capabilities leading to an increased sense of job satisfaction and

Implementation strategies	Outcomes on providers
External clinical mentor coach to support the clinical mentors. Web-based networking tool to facilitate peer networking and support for clinical mentors. Workshops for clinical mentors and champions. Additional strategies identified in the action plan developed by the action research project in each aged care service, in one of four clinical areas.	reduced levels of staff turnover in participating sites. Clinical mentors experienced professional development and leadership growth and developed their ability to provide on the job support for site champions and mentees.
CC6	
Workshops for providers to explain the resources (which can assist organisations to provide person-centred services). Hard copies of resource document distributed to providers.	As no individual provider has used the Resources to develop and implement an action plan, it is premature to evaluate whether the Resources have led to an increased use of evidence in everyday practice.
RC3	
Action learning teams formed in participating facilities with work of the teams guided by the TOrCCh model. External facilitator to support action learning teams. Project sponsor (usually the facility manager) with responsibility and accountability for the team and their project. Additional strategies in each facility as chosen by action learning teams.	Participants demonstrated evidence of staff development through the process of the project and valued working as part of a group. There was also evidence of individual development, positive effect (growth) and empowerment of individuals who had not previously 'stood out' in the facility. Communication and teamwork improved and staff got to know each other and those outside their work areas.

The three action learning or action research projects (CL1, CL2 and RC3) included teams of people working together in a 'cycle of change' approach for a common project goal. These teams had at its focal point a mentor or facilitator. Each of these projects was able to demonstrate improved levels of confidence, empowerment and competence in the staff that participated in the work groups. Both CL1 and CL2 reported that job satisfaction had also increased with CL2 indicating that this in turn led to reduced levels of staff turnover. CL1 and RC3 highlighted that teamwork had also improved. This is neatly captured in the following quote:

*There was evidence of staff development through the process, value in being part of group and project. There was also evidence of individual development, positive effect (growth) and empowerment of individuals who had not previously 'stood out' in the facility. Communication and teamwork improved and staff got to know each other and those outside their work areas. (RC3 final report, p.31)*

These positive outcomes were also reported in the evaluation team interviews with key stakeholders. The two most dominant themes coming out of these interviews were teamwork and increasing staff confidence. Many comments were made in relation to teamwork. Staff from each of the action learning or action research projects talked about improved communication and collaboration between different staffing groups; both direct and indirect care. Staff also appreciated the inclusiveness of teamwork and felt that prior to the EBPAC project they tended to work in 'silos'. Staff from indirect care disciplines appreciated how their input to a project positively affected client outcomes. As one staff member put it: staff are 'are able to contribute to the bigger picture', they 'understand how catering can make a direct contribution to end of life care for a resident' (CL1).



With regards to increasing confidence, one staff member felt that their 'opinions were valued', giving them a sense of 'self-belief' (CL1). In another example, one staff member commented:

*Increased confidence also means they [staff] are willing to speak up about concerns they might have [about a resident] and will not just wait till someone else [perhaps more appropriate] gets involved; they now 'intervene earlier and trust their own judgement'. (CL1\_2)*

Raising an individual's confidence is ultimately empowering. According to one staff member as a result of the EBPAC project, 'staff have a real appetite for change and to try new things' (CL2). In another example:

*People now speak at meetings that would not have before. It has made staff realise their own strengths and where they would like to develop their skills (RC3\_2).*

For some individuals this sense of confidence led them to extend their roles with the organisation:

*A couple of torch girls are now in the job exchange program within our organisation. We have quite a few opportunities that staff can get involved in. They can work in head office or in community care. They apply for a two week job exchange to do something different and two of my TORCCh girls have done this. One is working in quality and one in projects. I feel as though my staff have blossomed. (RC3\_2)*

The fourth system level project (CC6) developed an 'organisation improvement' resource designed to be used by community organisations to assess how well their structures, systems and processes facilitate a person-centred approach. This approach was based on a Plan Do Study Act (PDSA) model of quality improvement and was limited to the development and distribution of the resource. This resource had not been used by an individual provider at the time of writing this report therefore it is premature to evaluate whether the resources had any positive impacts or outcomes on providers.

#### 4.2.2 Provider impacts and outcomes: Community care projects

*Five EBPAC community care projects developed implementation strategies that were primarily targeted at providers (CC1, CC2, CC3, CC4 and CC5). Each of these strategies had a strong emphasis on training staff. Two reported that staff had increased levels of job satisfaction as a result of their involvement with the EBPAC project (CC2 and CC3). An increased level of knowledge was another positive outcome for providers from these projects. This is perhaps not surprising given the strong focus on training staff. This knowledge enabled some providers to 'increase their roles and responsibilities' (CC1), others felt that it increased their levels of confidence in engaging with clients (CC2 and CC2). There was also some evidence that this knowledge was being applied in the home care environment (CC5). Outcomes reported in the projects final reports are summarised in Table 19.*



**Table 19** *Provider impacts and outcomes: Community care projects*

Implementation strategies	Outcomes on providers
<b>CC1</b>	
<p>Funding to cover the cost of staff training.</p> <p>Establishment of LUPP teams (of nurses) at each implementation site.</p> <p>Education of nurses to use Leg Ulcer Prevention Program (LUPP).</p> <p>Workshops on clinical leadership for team leaders (LUPP project).</p> <p>Education of clients using the LUPP package (six sessions), primarily by using a portable DVD player.</p> <p>Provision of LUPP kit to clients (containing DVD, book, drink bottle, tape measure, skin care samples, two sets of four layer compression bandages and a leg protector).</p> <p>Education of community care aids to use Skin Awareness Program (SAP).</p> <p>Education of clients using the SAP e-learning package.</p> <p>Provision of SAP kit to clients (containing DVD, book, skin care products and first aid packs)</p> <p>Assessment of skin risk and use of skin inspection progress record.</p> <p>Clinical Leadership Group, including local champions, to provide clinical leadership for evidence-based wound management.</p>	<p>The nursing staff delivering LUPP felt that LUPP taught them additional information about the care of people with venous leg ulcers, and also systematised the care they already delivered.</p> <p>The health workers who had SAP training also increased their knowledge of skin health.</p> <p>Facilitating SAP led health workers to increase their roles and responsibilities which led to a more collaborative approach in care delivery by care providers.</p>
<b>CC2</b>	
<p>Train care workers to include interventions in usual care.</p> <p>Include interventions in client care plans.</p> <p>Train case managers to include interventions in client care plans.</p> <p>LEAP champions at each implementation site to support case managers.</p> <p>Train LEAP champions.</p>	<p>Both case managers and care workers reported an increase in their confidence to socially and recreationally engage clients. Case managers also reported an increase in job satisfaction</p>
<b>CC3</b>	
<p>Training of care workers and case managers by a music therapist.</p> <p>Education of care workers and case managers on the physical and psychological changes of elderly people.</p> <p>Education of clients and family members (about dementia and memory loss).</p>	<p>Health care workers reported increased levels of job satisfaction after seeing the positive mood improvement of their clients.</p>
<b>CC4</b>	
<p>Training of case managers, personal carers and other members of the aged care workforce.</p> <p>Use of client assessment and care planning tools.</p> <p>Mentoring and support of case managers.</p> <p>Client forums to provide information to clients to assist them in understanding the activities required for higher levels of self-direction.</p>	<p>Survey data revealed that most Case Managers felt their agencies' had left them under-prepared to practice some of the implementation elements in the workplace.</p> <p>Feedback from Case Manager interviews provided mostly positive anecdotal support for the CHOICES model. They embraced the aspirational goal setting concepts, the flexibility of spending options, and enabling their clients to set the agenda for meetings and care related discussions.</p>
<b>CC5</b>	
<p>Training of community aged care staff in oral health care, oral health assessment and care planning.</p> <p>Provision of oral health self-care booklet and bathroom prompts to clients.</p>	<p>Home care staff responses were highly positive of the oral health care education</p> <p>There was evidence that home care staff were applying new oral health knowledge not only to client care but to themselves.</p>

Implementation strategies	Outcomes on providers
Use of 6-question oral health assessment tool. Use of oral health care plans. Referrals to dentists for dental examination and treatment.	

Many different themes came out of the key stakeholder interviews. The most common was the belief that relationships between health care workers and clients had improved as a result of the EBPAC intervention. This is neatly summed up in the CC3 Music project. In a focus group held with 13 aged care providers there was a consensus that if the client was happy then it made the job of the aged care worker easier. In this instance the playing of tailored Chinese music was an enjoyable experience for the client and it also provided an opportunity for positive interaction with the aged care worker. One respondent indicated that it was 'good for aged care workers to deal with happy clients' (CC3).

This is also evidenced in CC2 where the whole focus of the project is to engage with clients in a positive fashion and increase client activity. According to one LEAP champion the project 'increased their [care workers] skill set in engaging with clients' (CC2). In the CC4 project improved relations between health care workers and clients was also mentioned. This was in reference to a perceived 'cultural shift' in provider-client relations. Two different care workers commented that they have a better understanding of the clients' needs as a result of the project. As one provider commented:

*Staff now understand the specific needs of their clients, transport is a huge issues. It is no longer about vacuuming the house (CC4\_6).*

Another common theme was increased knowledge of aged care workers. Many of these comments related to CC1 Chronic wounds. Three aged care workers commented that they had increased their knowledge as a result of the project. The best example is provided:

*For me the benefit was that I learned a lot of things - I now look closer and observe wounds and get nursing assistance where appropriate. I am more vigilant and know what to look for. (CC1\_1)*

This increase in knowledge has also led to an increase in aged care workers confidence. This is captured in the following statement.

*CHOICES has enabled me to become more articulate in defending the right of the client, it has given me confidence and strength to deal with clients. (CC4\_4)*

Despite these positive outcomes many of the stakeholders interviewed as part of the national evaluation commented that the EBPAC initiatives resulting from the projects were time consuming for aged care workers. In one project alone (CC1) four out of the five stakeholders interviewed made a comment about the length of time the project took. Two of these comments related to the fact that whilst time was provided to carry out the project activities during the funding period this was not the case after funding stopped. This is captured in the following two statements:

*The program takes time, the first 4 out of 10 sessions take one hour each. This was included as part of the 10 week SAP program. Post program we do not have time to do this as we are too busy showering clients etc. (CC1\_1)*

*In the program, RDNS gave staff extra time to carry out the 10 week project with clients. This is not possible outside of the project, after program there is simply no time to work closely with clients on this issue alone. (CC1\_1)*

#### 4.2.3 Provider impacts and outcomes: National roll-out projects

Table 20 summarises implementation strategies targeted at providers from the two national roll-out projects.

**Table 20** *Provider impacts and outcomes: National roll-out projects*

Implementation strategies	Outcomes on providers
RC1	
Updating and refining resources from EBPRAC and disseminating the resources by running workshops across the country.	<p>It was reported that the workshop increased participants' understanding about a palliative approach and how to use the PA Toolkit resources to implement a palliative approach within their facilities.</p> <p>After Death Audits indicate that staff have improved their knowledge and skills in conducting a palliative care case conference and using an end of life care pathway.</p>
RC2	
Updating and refining resources from EBPRAC and disseminating these resources by running train-the-trainer workshops across the country for people who had been identified by their facility as skin integrity champions.	<p>Feedback from workshop participants was positive and pre/post surveys of participants found significantly improved confidence in managing common wound types in older adults, finding and applying evidence in their practice, and implementing change in their workplace.</p> <p>Staff outcomes from CSI wound projects included increased education provided, improved knowledge, and implementation of protocols and resources which lessened workload.</p>

Again, little data was collected by RC1 relating to provider outcomes. It was reported in their final report that the national rollout workshop increased participants' understanding about a palliative approach and how to use the PA Toolkit resources. It is also reported that the After Death Audits indicate that staff have improved their knowledge and skills in conducting a palliative care case conference and using an end of life care pathway.

RC2 collected data on provider outcomes through the workshop participants' pre and post surveys. It is reported in the RC2 final report that workshop attendees had statistically significant improvements in their level of confidence in a variety of areas including; identifying and managing a variety of wounds, applying best evidence in their clinical practice and empowering others to make change.

Data collected from the evaluation survey and key stakeholder interviews did elicit more information relating to provider outcomes. Of those facilities that had commenced or fully implemented the CSI initiative, 82.6% (n=19) indicated that the use of evidence-based practice (EBP) had improved since the initiative had been implemented. As a result of this move towards evidence based practice some participants stated that there had been improved outcomes at their facility, including a decrease in wound and injury rates. Several

participants also noted positive changes in staff awareness and understanding related to wound and skin management.

In terms of knowledge and skills of providers, 87% of participants (n=20) indicated that this area had improved. Seventy four per cent (n=17) indicated that clinical leadership had improved within their facility.

Of those facilities that had commenced or fully implemented the Palliative Care Toolkit, 82% (14) indicated that the use of evidence-based practice (EBP) had improved since the initiative had been implemented. In terms of knowledge and skills of providers, 82% of participants (n=14) indicated that this area had improved. Almost 90% of respondents that had commenced or fully implemented the Palliative Care Toolkit (n=15) indicated that clinical leadership had improved within their facility as a result of adopting the Palliative Care Toolkit.

### 4.3 *Impact and outcomes on the aged care system*

This section describes the implementation strategies applied by each project and their impact and outcomes on the aged care service system. The expression 'system' can be understood at two levels:

- that of the individual organisation (e.g., changes to policy and practice); and
- that of the broader aged care sector

As noted previously in Figure 2, the main project activities were directed at either two or all three levels of the evaluation framework. Importantly, all projects included consideration of the broader system implications in one way or another, reflecting their requirements of the overall program evaluation.

All participating organisations benefitted directly from EBPAC by accessing the training resources. In the main, these were provided at no cost to the organisation. Consequently, the sector overall has a much richer skill set amongst a proportion of its staff which should, to some extent, result in improved outcomes for clients. Improved access to evidence based resources and tools and the development of research and project management skills is now more widespread.

A recurring outcome was the relationships that aged care organisations developed and/or strengthened as a result of participating in EBPAC. These include links with academic institutions, mainstream services, and inter- and cross-sector organisations.

Each EBPAC project incorporated researchers, academic institutions and industry experts in a range of roles – as project lead, evaluator, partner, or part of its governance arrangements. The centrality of this role was primarily to ensure the validity of the evidence underpinning the projects. Additional benefits, according to a number of stakeholders, were primarily reputational: 'there is value in supporting evidence' as it provides an organisation with 'credibility' and 'participation in research...is good marketing' (RC3), (CC4). The relationships were mutual, providing researchers with a better understanding of the contexts in which knowledge translation activities are being delivered; one academic noted

that this would directly influence the content and nature of the post-graduate course they were planning to run in the future (CL2).

Links with mainstream advocacy, organisational development and training services also featured positively, particularly in terms of providing new ways of doing things (e.g., CL1 – Harrison Assessment competency profiling), dissemination (CC1 – Council on the Ageing peer education) and sustainability (CC2 – Arts Health Institute training).

Cross-sector linkages that were established and/or enhanced also provided organisations with opportunities for future partnerships (e.g., CC1, CL1), improved access to services (CC5, CL2), resources and funding (CC1, CC6) and also ensured newly acquired skills were aligned with industry competencies (CL1, CC5).

More detailed information about the impacts and outcomes of the different types of projects follows.

#### 4.3.1 System impacts and outcomes: Leadership and change projects

Table 21 highlights system level activities applied by the leadership and change projects. Again, the relevant outcomes are synthesised from the projects final reports.

**Table 21** System activities and outcomes: Leadership and change projects

System level activities	Outcomes on the system
<b>CL1</b>	
<p><i>Aged care organisation:</i></p> <p>Competency profiling using Harrison Assessment to determine staff capability</p> <p>Delivery of Leadership workshops</p> <p>Action research projects undertaken that aligned to strategic objectives and/or local priorities.</p> <p>Multi-disciplinary project team membership</p> <p>Engagement of management in post-project showcase event.</p>	<p>Clarification of key capability needed to underpin workers' preparedness to take initiative, problem-solve and deliver on person-centred care with a focus on client needs.</p> <p>Improved communication and relationships across work teams.</p> <p>Enhanced research skills of staff participating in action research projects, including ability to access evidence and develop strategies to address issues that arise.</p>
<p><i>Aged care sector:</i></p> <p>Development of Emerging Leaders resource package targeting care workers and non-clinical staff working in aged care</p> <p>Aligning outcomes to Industry Skills Council competencies</p>	<p>Resources developed within vocational education sector, and aligned with VET/TAFE processes/developments</p>
<b>CL2</b>	
<p><i>Aged care organisation:</i></p> <p>Site-specific projects that aligned with local priorities determined through quality improvement processes.</p>	<p>Project outcomes incorporated into organisations' governance plans and reflected in care plans, protocols and procedures.</p> <p>Demonstrated improvements in staff retention and quality of care within project sites that used this new model.</p>
<p><i>Aged care sector:</i></p> <p>Development of Aged Care Clinical Mentor model and a six step Aged Care Clinical Mentor Model of Change, supported with resources to document each step of the process.</p>	<p>Clarification of an aged care clinical mentor model that has clinical expertise and local mentoring capacity, but also is able to work at the macro level of business, working closely with management to address any identified clinical area of concern that requires continuous improvement through the implementation of best clinical practice.</p> <p>Clarification of 'change management' role and strategies to plan, engage others and implement sustainable new clinical</p>

System level activities	Outcomes on the system
	practices within a continuous improvement framework.
RC3	
<i>Age care organisation:</i> TOrCCH model refined and resources developed Projects aligned with local priorities Multidisciplinary approach Additional strategies in each facility as chosen by action learning teams.	Communication and relationships between staff improved; TOrCCH resource kit provided to each participating organisation; No evidence of impact on staff retention and/or turnover due to incomplete data;
<i>Aged care sector:</i> Pilot change management model for use within aged care sector.	TOrCCH model clarified and associated resources (education modules, tools etc.) provided to participating facilities and Department of Social Services for potential replication in other settings.
CC6	
<i>Age care organisation:</i> Capacity building workshops held with representatives of each Alzheimer's Australia State and Territory office, to prepare for ongoing consultancy role to support sustainability of the resource.	Development and distribution of resource 'Valuing People' to support organisational self-assessment of client-centred practice. Each State and Territory AA office received 50 copies and the National office 200 copies to distribute through their respective networks. Most of the Alzheimer's Australia State and Territory offices do not have a plan or strategy for ongoing promotion of the Resources.
<i>Aged care sector:</i> National distribution to all packaged care providers and a number of HACC service providers.	Valuing People resource distributed to 835 providers across Australia. Limited involvement by other industry peak bodies. Promotion of resources via five industry conference presentations; two industry conference information stands; and three articles in industry magazines and newsletters.

These four projects focussed on the development of new models of effecting change within aged care. RC3 sought to resource aged care services with tools and strategies that can be applied generically within an aged care service, while CL1 and CL2 focussed specifically on development of a model of leadership in knowledge translation in clinical and care practices. CC6 developed a resource to assist providers undertake organisational self-assessments regarding their capacity to provide person centred care. Underpinning each of these was a multi-disciplinary approach to addressing issues of local and/or strategic significance.

Participating organisations were provided with education/workshops, resources and tools, as well as mentoring and/or ongoing support from the project leads throughout the project. Outcomes included changes to organisational culture and staff relationships, policies and procedures, quality improvement processes and workforce participation. In most cases, the small project teams at the individual service level included people who had self-nominated and collaboratively identified the area of practice change on which to focus based on relevant data and input of members. A major outcome of this approach appears to have been on organisational culture, in particular improving staff relationships and

communication, as staff formerly separated by nature of their job description (e.g., care worker, nursing, hospitality, cleaning) worked together towards a common goal.

*Participants learned new skills, new respect for one another's expertise and capabilities...(it) broke down barriers between direct care staff and those working behind the scenes. (CL1\_1)*

*The simple things like leading a meeting and feeling like you can talk to a manager and share ideas has been very important. (RC3\_1)*

By aligning projects to strategic imperatives and local priorities, staff also demonstrated a heightened awareness of their individual contribution to the overall organisational objectives.

*Hospitality staff now understand how catering can make a direct contribution to end of life care for a resident. (CL1\_1)*

Organisational benefits of these initiatives include enhanced clinical practice as staff applied their newly acquired confidence and clinical skills, utilised the tools and resources developed, and adhered to updated policies and procedures.

*There has been a reduction in the reported resident incidents relating to behaviours of concern at the site over the term of the project. Staff are now identifying, assessing and managing pain within best practice guidelines. (CL2\_7)*

The strategic and/or local priorities of the projects were generally identified through existing quality improvement processes such as quality audits, incident registers etc. These provided an overall framework in which to set the project, ongoing monitoring and review and were particularly helpful in engaging management and Boards in regards to the more clinically focussed projects undertaken by most of the CL1 and CL2 sub-projects. Some of the larger organisations were able to use the tools and processes developed to 'standardise approaches' across sites and service settings, and benchmark against like services.

*Through the education of the personal care workers around initial management of skin tears, we then provided education to Enrolled Nurses and Registered Nurses (who worked in residential care). (CL2\_4)*

The majority of participating organisations incorporated some or all aspects of their project into existing local policies and procedures, resulting in more evidence-based assessment processes, accessible information and resources, staff education and training schedules and role redesign.

A small number of participating organisations did not appear to have embedded changes arising from projects. This included one site where the project was determined by 'head office' and allocated staff were informed they were to present themselves at a workshop the following week.

*We were just told to do it ... and attend workshop at head office... that was immediately off-putting for a number of staff. (CL1\_4)*

This approach appeared to impact on the level of engagement by team members and potential gains from participation in the project; the organisational representative went on to note that there had been no changes to policies and procedures arising from the project.



All three projects included measures of staff engagement and two sought to measure workforce changes. In some cases, managers expressed surprise at their staff members being motivated to pursue promotion or other developmental opportunities as a direct consequence of their involvement in the project (CL1, RC3). One project noted that its seven participating sites achieved a decreased staff turnover rate at twelve months after the implementation of the project:

*It is not possible to link the decrease in staff turnover solely to the implementation of the project however it is reasonable to assume that the positive and engaging nature of the project for (participants) contributed to the result. (CL2\_5)*

The CC6 project primarily developed an organisational self-assessment resource. However, they also conducted national workshops. A specific objective of the workshops was to build capacity in the lead organisation's national network to extend the range of services currently provided through offering consultancy services in undertaking self-assessments; this was also being considered as a future revenue stream for one of the pilot partner organisations.

*We may even think of developing a training and education service around person-centred care that we can deliver to other organisations on a consultancy basis, using our own organisational experiences as a case study. (CC6\_1)*

Organisational culture was a recurring issue raised by stakeholders, with some organisations being 'transformed' as a result of participating in the project (CC6). The centrality of organisational culture to effective implementation of evidence based practice resulted in one project completely reworking its overall approach.

*This was initially conceived as a project that would be consumer-focussed, but then we realised that this couldn't be achieved unless an organisation also was staff-focussed.... So we reframed the tool to be a framework that focussed on relationships. (CC6\_2)*

#### 4.3.2 System impacts and outcomes: Community care projects

Table 22 highlights system level activities applied by the EBPAC projects targeting the community. Again, the relevant outcomes are synthesised from the projects final reports.

**Table 22** System activities and outcomes: community care projects

System level activities	Outcomes on the system
CC1	
<p><i>Aged care organisation:</i></p> <p>Inclusion of key stakeholders on project consortium, in particular Vic Health and SilverChain.</p> <p>Clinical leadership training and evidence-based practice education was delivered during the first and second project workshops.</p> <p>Testing implementation of a Leg Ulcer Prevention Program (LUPP) and the Skin Awareness Program (SAP)</p>	<p>Involvement of Vic Health provided 'legitimacy to the work', and managers at the respective organisations were keen to participate; Also provided additional funding for last clinical leadership workshop to be face-to-face rather than via teleconference as originally planned</p> <p>Strengthened relationships between RDNS and Vic Health and SilverChain</p> <p>Developed new relationships with Austin Health Wound Clinic, to facilitate transition from acute to home care.</p> <p>Resources developed, strategies clarified and enhanced evidence base for LUPP and SAP.</p>
<p><i>Aged care sector:</i></p> <p>Commencement of clinical leadership model</p>	<p>Aspects of a clinical leadership model clarified and tested, however attributes and strategies to implement the model are yet to be developed.</p>



development	Clarification of strategies for chronic wound management and to improve skin care could potentially reduce longer term burden on care and health systems.
CC2	
<i>Aged care organisation:</i> Education and change management strategy developed to enhance staff appreciation of the importance of social and recreational activities for clients within a consumer directed and wellness model of service.	Social and recreational goals incorporated within client care planning processes.
<i>Aged care sector:</i> Pilot a service model to enhance opportunities for clients' social and recreational needs to be met.	Development of service model and resources to support delivery of more individually tailored services that aligns with consumer directed care and wellness reforms.
CC3	
<i>Aged care organisation:</i> Development and trial of Chinese specific music and resources including Preferred Music Listening Program Music Packages, Step-by-Step Manual, individualised song book and CD; Establish Chinese Music Library; Utilise existing specialist mainstream services and resources e.g., Alzheimer's Australia VIC; and qualified music therapist	Enhanced capacity of CCSSCI to deliver music therapy in addition to routine service provision. Music Library can be used for individual clients as well as organisational celebrations and gatherings. Strengthened relationships between AA Vic and Chinese Community Social Services Centre (CCSSCI).
<i>Aged care sector:</i> Pilot of Home-based Preferred Music Listening Program Music Packages, including Step-by-Step Manual, individualised song book and CD.	Development of a service model and supporting resources that can be replicated by organisations supporting people of different cultural and linguistic backgrounds.
CC4	
<i>Aged care organisation:</i> Development of E-learning package, delivery of workshops and staff mentoring to support CDC in a range of contexts and client types. Project lead aged care provider is influential member of a national network that has the largest share of aged care places.	Integration of project outcomes into routine assessment and care planning processes and documentation of participating organisations. Additional strategies and resources provided to support staff working in remote locations during project implementation. Capacity for national application amongst sister aged care service organisations interstate.
<i>Aged care sector:</i> Refinement of a service model (CHOICES) to support the delivery of consumer directed care for non-mainstream Home Care Package clients e.g., CALD (Greek); ATSI and rural and remote.  Project lead partnership with Deakin University	Development of service model for improved quality of case management within a CDC environment. Improved evidence base generated regarding preference of older people for more decisional authority and choice. Confirmation that online training on its own 'adds little in terms of implementing evidence-based guidelines into practice'.
CC5	
<i>Aged care organisation:</i> Development of localised Communities of Practice (CoPs) within participating agencies; Cross sector engagement strategies such as localised dental referral pathways developed to facilitate project implementation;	Integration of the six question oral health assessment into general health assessment processes of participating organisations, and oral health care planning incorporated into revised care plans. CoP developed amongst home care project officers leading implementation, but not at local organisational level. Improved communication and referral pathways between aged care services and local dental services.
<i>Aged care sector:</i> Development of a multidisciplinary model of oral health	Resources produced to support BBOHC in community that align closely with existing national resources for residential aged

<p>care in the home care contexts aligned to national dental and aged care policy developments.</p> <p>Development of resources to improve oral health care delivery in home care settings, including:</p> <ul style="list-style-type: none"> <li>• Better Oral Health Guide for Home Care resource (based on former Residential Aged Care guide).</li> <li>• Oral health reporting guide</li> </ul> <p>Resources were also produced to raise the oral health awareness of older people and their families.</p> <p>Support from University of Adelaide School of Nursing in the use of 'engaged scholarship', a participatory research approach.</p> <p>Project processes and resources built on the Better Oral Health in Residential Care Model that was delivered nationally to all aged care services.</p>	<p>care.</p> <p>Targeted resources and service model developed for Aboriginal and Torres Strait Islander communities.</p> <p>Explicit alignment of resources and service model to National Oral Health Plan and the National Partnership Agreements to improve oral health and access to care for vulnerable population groups; and to aged care reforms regarding consumer directed care and wellness.</p> <p>Vocational aged care training links were made by relating resources to the Community Services and Health Industry Skills Council oral health competency recommendations.</p>
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The community care projects were similar to the projects funded in earlier EBPAC rounds in that they had a focus on upskilling staff in the use of specific techniques or clinical practice.

As with the clinical leadership and organisational change projects, organisations involved in the community care projects were provided with education/workshops, resources and tools, mentoring and/or ongoing support from the project leads throughout the project. The majority of organisational impacts appear to be in terms of changed policies and procedures, quality improvement processes, preparedness for sector reforms, enhanced scopes of practice and competitive advantages.

The majority of participating organisations incorporated some or all aspects of their project into existing local policies and procedures, particularly in terms of using evidence-based assessment tools to support care planning (CC1, CC2, CC4, CC5). This mostly involved refinement of existing processes to align with evidence based best practice (CC1, CC5).

*We already had policies in place for wounds...we are trying to embed education into our practice...the regional wound committee is very keen to support it. (CC1\_8)*

The changes mostly occurred in those organisations where local management was actively engaged in and supportive of the project. For one participant who worked in a large decentralised organisation it was more difficult to influence change.

*I was hoping to have the actual questions included in the organisation's initial assessment, but the forms committee didn't agree...I've now included in the staff responsibility folders so staff are reminded what to ask when the prompt...comes up. (CC5\_2)*

Both CC2 and CC4 trialled new service models and therefore organisational changes were more significant.

*Clients all have lifestyle goals. LEAP is part of their care plan...meeting lifestyle goals is part of what (staff now) do. (CC2\_3)*

*To implement all the recommendations requires quite a significant rejigging of operational procedures, staff time and training, etc. (CC4\_8)*

The uptake of project outcomes by participating organisations appears to be directly influenced by the consumer directed care (CDC) focus of the government's aged care

reforms. CC4 sought to explicitly clarify the organisational changes required to meet the needs of consumers from rural and remote, Greek and Aboriginal and Torres Strait Islander community backgrounds. Likewise, CC2 and CC3 trialled models that would enable organisations to deliver more individually tailored services.

*It isn't rocket science ... social and recreational goals are important too...are all part of the CDC approach. (CC2\_1)*

The policy context of CDC is intertwined with the concept of enablement and wellness that also underpinned several projects (CC1, CC2, CC3). Consequently, take-up of project outcomes made sound business sense for participating organisations.

*It's a competitive market place out there and agencies need to show they are different. (CC2\_5)*

While most participating organisations were able to enhance the quality of services as a result of their participation in EBPAC, several were also able to extend the range of services they provided. For example, the new service models trialled in CC2 and CC3 offered tangible additional activities that organisations could offer clients.

*The service scope of (organisation) has been broadened to include music intervention, as part of the care options available for clients. The holistic approach of the care services is further expanded. (CC3\_3)*

The lead organisation for CC1 has subsequently been able to extend the scope of service to include a different service sector than their traditional client group.

*The (organisation) has traditionally worked with an internal focus. Now we are focusing on innovations that have system-wide focus. (CC1\_6)*

#### 4.3.3 System impacts and outcomes: National roll-out projects

The two national roll-out projects were designed to have the greatest impact on the aged care system, being funded to deliver comprehensive evidence based resources and training to residential aged care services to support evidence based practice in palliative care and wound care and skin integrity (see Table 23).

**Table 23** System activities and outcomes: national roll-out projects

System level activities	Outcomes on the system
RC1	
Age care organisation: Palliative Approach Toolkit disseminated nationally and training made available free of cost. Offer of participation in sector wide audits to assist facilities in their quality improvement processes.	The use of palliative care case conferences and the use of an end of life care pathway increased following the PA Toolkit workshops. Many facilities have reviewed their end of life care strategies and processes and have developed, or commenced implementing, a comprehensive, sustainable palliative approach to care in their facilities. In pre- and post-implementation audits there were significantly more palliative care case conferences conducted, and clients commenced on an end of life care pathway (EoLCP); However, there was no significant difference in the number of advance care plans developed.
Aged care sector: Refinement, production and national distribution of Palliative Approach (PA) Toolkit.	PA Toolkit distributed nationally prior to training being made available. 2,720 kits were provided to approved RACFs, 70 to other RACFs

<p>National delivery of one day intensive workshops</p> <p>The toolkit included templates for advance care planning, case conferencing and end of life care pathways, as well as templates for After Death Audits, and Organisational Policies and Structures Audits to assist RACFs with a system for audit and feedback and to monitor quality improvement</p>	<p>(i.e. private, multi-purpose sites and new facilities), and 210 to organisations to support RACFs to implement the palliative approach including the VPCC - Victorian Palliative Care Council (???) aged care trainers, and SPCS. (not sure what these are)</p> <p>Approximately 2,250 staff from 1,276 RACFs nationally were trained:</p> <ul style="list-style-type: none"> <li>42 workshops to promote the use of the PA Toolkit to RACF management, educators, staff and external providers.</li> <li>19 one day train-the-trainer workshops were held in Victoria for the VPCC.</li> </ul> <p>There is an increased understanding of the benefits of implementing the PA Toolkit and staff are better able to undertake this following the workshops.</p> <p>The pre and post implementation audits reveal that there was little difference between the number of RACFs claiming Complex Health Palliative Care through ACFI; and no significant changes in numbers of clients transferred to hospital in last week of life or their place (i.e., RACF or hospital) of death.</p>
RC2	
<p><i>Age care organisation:</i></p> <p>CSI workshop attendees were asked to develop and start on their own change management plan and specific goals to implement the CSI model within their facility or organisation, aligned to strategic priorities and/or local contexts.</p>	<p>335 facility level project plans submitted post-workshop, major features of which were:</p> <ul style="list-style-type: none"> <li>establishment of CSI teams</li> <li>implementation of the CSI model and resources i.e. regular meetings for feedback, audits, evaluations, monitoring, resident surveys, cost comparisons, incorporating a skin integrity/wound care standing item on regular staff meeting agendas</li> <li>incorporation of the CSI materials into e-pathways and e-learning portals, access via links within a web site and/or organisation intranet, and incorporation of the CSI strategies into a learning calendar, and</li> <li>CSI incorporated in governance, research and planning consultation</li> </ul>
<p><i>Aged care sector:</i></p> <p>Refinement, production and national distribution of CSI resource package;</p> <p>Delivery of a one day, intensive workshop focussed on providing attendees with the knowledge and skills to implement the CSI model of wound management; and</p> <p>Conduct of a series of Promoting Healthy Skin 'Train the Trainer' workshops in the capital cities and major regional centres throughout Australia</p>	<p>6,000 CSI resource packages were distributed, with each residential aged care service receiving one prior to the delivery on national workshops.</p> <p>Thirty seven workshops were delivered to 1286 participants who represented 835 facilities.</p> <p>CSI kits and resources have been provided to other stakeholders, such as health professionals or other interested groups or networks with an interest in care of older adults.</p>

It can be assumed that the aged care sector is better resourced to meet the palliative needs of residents as a result of the palliative care initiative. The final report notes an increase in palliative care case conferences and end of life care pathways by those participants that responded to post-workshop data collection, and many facilities reviewed their end of life care strategies and processes. There were, however, no significant differences in the number of advance care plans developed or ACFI claims for the Complex Health Palliative Care. An outcome that could reasonably be expected to result from the initiative is a reduced impact on the related health system as a result of RACFs better meeting the palliative care for clients; however, there was no significant change in numbers of clients being transferred to hospital in last week of life, or their place (i.e., RACF or hospital) of death.

Similarly, it is expected the CSI roll-out has resulted in improved access to skills and resources across the residential aged care sector. Workshop participants were encouraged to apply their newly acquired knowledge to their workplace in the form of a project plan. A total of 335 facilities submitted project plans to the CSI project leads, outlining their proposed strategies. The major activities were:

- establishment of CSI teams
- implementation of the CSI model and resources i.e. regular meetings for feedback, audits, evaluations, monitoring, resident surveys, cost comparisons, incorporating a skin integrity/wound care standing item on regular staff meeting agendas
- incorporation of the CSI materials into e-pathways and e-learning portals, access via links within a web site and/or organisation intranet, and incorporation of the CSI strategies into a learning calendar, and
- CSI incorporated in governance, research and planning consultation

## 5 COSTING ANALYSIS

This costing analysis is partly based on the financial information provided by each of the projects in their regular six-monthly reports together with the audited accounts provided with Final Report (Part 2). The completion dates of some of the projects were extended and as a result some financial information was unavailable at the time of writing this report. This report takes into account all financial information available up until 20 March 2015.

The EBPAC initiatives included a diverse range of funded projects. For many elements, there were complex causal relationships between project interventions and potential health outcomes and many of the impacts are extremely difficult to quantify. This limited the extent to which traditional economic evaluation methods could be performed. Therefore, this economic evaluation focused only on the return on investment for funding of the EBPAC initiative for government and providers.

The economic evaluation uses two primary sources of information. On the one hand, it is based on the individual project funding agreements between the Department of Social Services in which the total funded amount is outlined together with broad categories of planned expenditure. On the other hand, the receipts and expenditure reports provided as part of the regular project six-monthly reports provide a more realistic idea of the actual expenditure. The dates provided in Table 24, Table 25 and Table 26 and summarise the latest available information.

If not specified otherwise, total expenditure excludes costs defined as compulsory under EPBAC because these costs were considered to be EPBAC-specific and would not be incurred outside the project. As much as possible, we attempted to identify relevant expenditure for the calculation of unit costs. For example, cost for resource development included only expenditure incurred for resource development and workshop cost only included expenditure directly related to that.

All values are rounded to the nearest Australian Dollar and exclude GST.

### 5.1 *Cost implications of leadership and change projects*

Table 24 shows for each of the four leadership and change projects the relevant unit of counting, which are the resources developed in CL1, CL2 and RC3. In CC6 the relevant unit is the number of health professionals and consumers that participated. The next column shows the respective expenditure per unit. The last two columns show the date of the latest available receipts and expenditure reported and the total funding received.

#### CL1

The CL1 project received funding of \$625,000 to develop and implement a competency based framework for building leadership capacities. This included learning and development methodologies as well as training resources. Unfortunately only limited cost information was available. Therefore, it had to be assumed that all project expenditure was incurred to develop and implement the resources at the participating facilities. As of 31 December 2014, the total expenditure was \$617,949.

**CL2**

According to the funding agreement, the CL2 project received \$1,200,000 to implement a clinical mentoring model in residential and community aged care services. Amongst other things, this model included a six step guide and a suite of resources. Unfortunately only limited cost information was available. Therefore, it had to be assumed that all project expenditure was incurred to develop and implement the resources at the participating facilities. As of 31 July 2014, the total expenditure was \$757,626. However, this represents a considerable underspend due to a delay in the start of the project and the withdrawal of two participating sites. At the time of writing this final report further financial information was unavailable.

**RC3**

The RC3 project was funded to develop, implement and evaluate a toolkit and training resource to support sustainable culture change in residential aged care facilities. The total funded amount was \$412,590. Again, only limited cost information was available. Therefore, it had to be assumed that all project expenditure was incurred to develop and implement the resources at the participating facilities. As of 31 May 2014, the total expenditure was \$338,431.

**CC6**

This project received funding of \$522,000 to assist community care providers deliver more person-centred care to people living with dementia. Unfortunately no receipt and expenditure information was available. Therefore all costs presented here refer to the original funding agreement. As part of the program 67 health professionals attended a train-the-trainer workshop. Total funding per attendee was \$7,104. Also 248 consumers participated in this project. The funding per consumer was \$1,919. Additionally, 835 community care providers received a hardcopy of the resources.

All four projects with focus on leadership and change are characterised by limited availability of cost information. Therefore it had to be assumed that the total expenditure in CL1, CL2 and RC3 were utilised in the development and application of resources. The two leadership programs CL1 and CL2 had similar costs, \$617,949 and \$757,626 respectively.

**Table 24**      *Leadership and change projects, expenditure and funding*

Code	Description	Expenditure per Unit	Date	Funded Amount
CL1	1 Resource	617,949	31/12/2014	625,000
CL2	1 Resource	757,626	31/07/2014	1,200,000
RC3	1 Resource	338,431	31/05/2014	412,590
CC6	67 Health professionals	7,104	---	522,000
CC6	248 Consumers	1,919	---	522,000



## 5.2 Cost implications of community care projects

Table 25 summarises the relevant unit of counting for each of the five community-based projects. For each unit of counting a separate line is used. In all projects the relevant units are: 'resources' and 'consumers'. In CC1, CC2 and CC4 the cost 'health professionals' is also relevant. The next column shows the respective expenditure per unit. The last two columns show the date of the latest available receipts and expenditure report and the total funding received.

### CC1

The CC1 project aimed to improve wound management in the community. According to the funding agreement \$728,000 of funding was received. As of 31 January 2015, \$638,914 was spent. This included \$31,373 for the development of resources. In total 329 consumers and 295 health professionals took part in the project. Total expenditure (excluding resource development) was \$1,847 per client and \$2,060 per health professional.

The final report of the CC1 project provides some additional information on expenditure relating to the Leg Ulcer Prevention Program (LUPP) and the Skin Awareness Program (SAP). These differ to some extent from the statements of receipts and expenditure available to us and are only provided for information. The development of the LUPP book and DVD was costed at \$18,034. Each participants received a LUPP kit at a cost of \$113. The development of the SAP package cost \$50,000 and each of the kits cost \$39.

### CC2

The CC2 program aimed at incorporating social and recreational activities into usual practice for home care clients. CC2 received \$801,400 funding. Total expenditure was \$720,469 as of 01 December 2014. The development of the training materials costed \$13,680. In total, 152 health professionals and 189 consumers participated in the program. The total cost per health professional was \$4,650 and \$3,740 per consumer, excluding resource development.

### CC3

The CC3 program received funding of \$270,000 to provide home based music listening to consumers. As of 31 October 2014 the total expenditure was \$261,739. This included \$7,176 for the development of resources. In total, 97 consumers took part in the program. Total cost for each was \$2,624.

### CC4

According to the funding agreement, the CC4 project received \$500,000 to increase the capacity of frail older people to design and direct their own care. As of 31 December 2014 only \$353,081 was spent. This represents a considerable underspend and is expected to change once the final statement becomes available. Expenditure relating to development of resources was \$12,515. The project cost for each of the 25 participating health professionals was \$13,622. An additional 127 consumers participated; the costs amount for each was \$2,681.



## CC5

\$1,297,000 of funding was provided to the CC5 model to encourage and support older people to maintain better oral health. As of 31 October 2014, \$177,206 of the total \$1,175,801 was spent for development of resources. 319 consumers took part in the program. The cost for each of them was \$3,130.

## Summary

Each of the five community projects developed resources. Expenditure across these projects varied, ranging from \$7,176 in CC3 to \$177,206 in CC5. Variation in cost per consumer (excluding resource development) was much less. Cost per consumer was lowest in CC1 with \$1,847 and greatest in CC2 with \$3,740.

**Table 25** *Community care projects, expenditure and funding*

Code	Description	Expenditure per Unit	Date	Funded Amount
CC1	1 Resource	31,373	31/01/2015	728,000
CC1	295 Health professionals	2,059	31/01/2015	728,000
CC1	329 Consumers	1,847	31/01/2015	728,000
CC2	1 Resource	13,680	01/12/2014	801,400
CC2	152 Health professionals	4,650	01/12/2014	801,400
CC2	189 Consumers	3,740	01/12/2014	801,400
CC3	1 Resource	7,176	31/10/2014	270,000
CC3	97 Consumers	2,624	31/10/2014	270,000
CC4	1 Resource	12,515	31/12/2014	500,000
CC4	25 Health professionals	13,623	31/12/2014	500,000
CC4	127 Consumers	2,682	31/12/2014	500,000
CC5	1 Resource	177,206	31/10/2014	1,297,000
CC5	319 Consumers	3,130	31/10/2014	1,297,000

## 5.3 Cost implications of national roll-out projects

Table 26 shows cost information for each national roll-out project. For each unit of counting a separate line is used. These are: 'cost for development of resource', 'per workshop', 'per attendee', 'per RACF represented'. The last two columns show the date of the latest available receipts and expenditure report and the total funding received.

## RC1

The RC1 project received funding of \$2,000,000 to undertake a national rollout of the Palliative Care Toolkit by organising training workshops and providing a toolkit for health professionals to help improve palliative and end of life care for RACF residents. As of 28 February 2015, total expenditure was \$1,414,053. Of this, \$226,262 was spent on the development of resources. Sixty one workshops were held and each workshop was attended by an average of 46 persons. In total 2,824 health professionals from 1,540 different RACF attended the training workshops. The cost of organising and running the workshops was \$47 per attendee. Total project costs per attendee were \$421, per RACF present at the workshops the total costs were \$771 and workshop specific costs were \$85.

The final report of the RC3 states that 3,000 copies of the toolkit costed \$131,860. Hence, each toolkit cost \$44.

## RC2

According to the funding agreement the RC2 project received funding of \$967,287 (including additional funding) to implement the Champions for Skin Integrity (CSI) model of wound care. The funding of this national rollout project was used to organise training workshops and to develop a toolkit. The development of this toolkit cost \$119,064.

Thirty seven workshops were held, costing on average \$5,172. Each workshop was attended by approximately 35 persons. In total 1,286 health professionals from 835 different RACF attended the workshops. The costs of organising and running the workshops were \$149 per attendee. Total project costs per attendee were \$660. Per RACF present at the workshops the total costs were \$1,016 and workshop specific cost were \$229.

The final report of the CSI project provides additional information regarding the cost per CSI resource kit. When printing 4,000 copies, each costed \$19.

The strategy of both national rollout projects was to organise a number of training workshops. Ideally the health professionals who attended the workshops would implement local changes to practice at their respective RACF. The resource development cost was \$226,262 in RC1 and \$119,064 in RC2. But cost per workshop was much less in RC1 (\$2,157) compared to RC2 with \$5,172. The cost difference per attendee was much less, \$421 in RC1 versus \$660 in RC2. The reason for that was primarily the number of attendees per workshop. In RC1, an average 46 health professionals attended the workshops while it was only 35 in RC2.

However, these figures should be read in conjunction with other parts of this report, especially regarding whether local changes were eventually initiated by the training workshops.

**Table 26** *National roll-out projects, expenditure and funding*

Code	Description	Expenditure per Unit	Date	Funded Amount
RC1	1 Resource	226,262	28/02/2015	2,000,000
RC1	61 Workshops	2,157	28/02/2015	2,000,000
RC1	2,824 Health professionals	421	28/02/2015	2,000,000
RC1	1,540 RACF	771	28/02/2015	2,000,000
RC2	1 Resource	119,064	31/03/2015	967,287
RC2	37 Workshops	5,172	31/03/2015	967,287
RC2	1,286 Health professionals	660	31/03/2015	967,287
RC2	835 RACF	1,016	31/03/2015	967,287

## 5.4 Summary

All 11 EBPAC projects provide additional value to their respective recipients. In each of the projects training materials, resources or toolkits were developed and supplied to health professionals and consumers. The costs per unit of counting differ fundamentally. These costs include resource development cost and cost per health professional or consumer. In a replication or wider rollout of any of these projects, resource development might be considerably reduced or in some cases may not be required. Therefore the costs per consumer or trained health professional provide an initial estimation of expected cost.

It is important to note that any comparisons between projects need to be considered within the context of the project's activities. In addition, the financial aspects of the projects should be considered in conjunction with other outcome measures described elsewhere in this report.

## 6 GENERALISABILITY

For the purposes of this evaluation generalisability has been defined as ‘are your lessons useful for someone else?’ Generalisability thus involves consideration not just of the ‘lessons’ but the mechanism for linking those lessons to someone (or somewhere) else. Within the context of the EBPAC program, the most relevant type of generalisability (except for the two national roll-out projects) is referred to as transferability, where an innovation in one setting is considered for adoption in another setting. Transferability is generally a joint enterprise between the evaluators of the original innovation (who need to present their findings in a way that is useful to others) and the readers of the results of that evaluation who may be trying to decide whether to adopt the innovation for their organisation. Sometimes there is a role for a third party (typically government) in facilitating transferability e.g. providing resources to assist with the uptake and use of what has been learnt. A good example of this is the way the RC1 and RC2 projects have promoted the generalisability of work done in the earlier rounds of the program.

The first step in facilitating generalisability is therefore to ensure that the reports and resources of the individual projects are freely available to the aged care industry. The proposal by the Department to develop a website targeting aged care workers and consumers that will include concise fact sheets about EBPAC-funded projects is expected to provide a platform for the dissemination of what has been learnt by each project. Additional strategies will be required to actively promote the site and facilitate access by the target audience of aged care consumers, workers and management.

### 6.1 Leadership and change projects

The most important enabler for the four leadership and change projects was a receptive context for change, with variations between projects in how this ‘receptivity’ manifested itself. As noted previously receptivity usually includes factors such as a need for change, a supportive culture which is conducive to innovation, managerial support, leadership, appropriate infrastructure and resources, and engagement of key stakeholders.<sup>30</sup>

Three of the projects used an action learning/action research approach which closely aligns with a continuous quality improvement perspective. This approach is widely used already, and requires considerable support, particularly from managers and the provision of sufficient resources to support the process. Those involved in action learning/action research teams need to be committed and actively participate, and often report a greater sense of personal development, ownership and engagement as a result of their participation.

The CL1 project was designed to clarify and support the TAFE sector to deliver leadership development programs for aged care staff, in particular those in non-clinical and/or non-professional roles. However, the materials and processes developed could also be

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<sup>30</sup> Dopson S, FitzGerald L et al. (2002) *No magic targets! Changing clinical practice to become more evidence based*. *Health Care Management Review*, 27 (3): 35-47.

Greenhalgh T, Robert G et al. (2004) *Diffusion of innovations in service organizations: systematic review and recommendations*. *Milbank Quarterly*, 82 (4): 581-629.

Pettigrew AM, Ferlie E and McKee L (1992) *Shaping strategic change*. SAGE Publications, London.

implemented by workplace development and training units of aged care organisations, or similar. The key factors for delivery will be having appropriate skills (including facilitation skills) and experience and a receptive environment. The clinical mentor model developed by CL2 requires a more sophisticated level of resourcing, in terms of the skills and attributes of individual staff undertaking the mentoring. Likewise, organisational factors such as workforce modelling, which includes a clear role definition, scope of practice and resourcing, will be important to underpin the implementation of the mentor model. Consequently, it is likely that this will work best in larger organisations which can scale costs across operational units. Alternatively, smaller facilities could band together to employ a mentor across a number of sites; again, this would need to be underpinned by clear role definition, scope and resourcing.

The RC3 project developed the TOrCCh resources, which are available on the website of the University of Western Australia's Centre for Health and Ageing. Although the resources have been designed for use without the need for external facilitation this still requires the receptive context referred to above. It is not clear whether further promotion of the resources should be actively pursued, given the limited evidence provided in the evaluation report about its advantages over other similar approaches. For example, the Australian Health Ministers' Advisory Council Health Care of Older Australians Standing Committee commissioned [The 'how to' guide: turning knowledge into practice in the care of older people, published in 2008](#), which targeted project officers and project managers involved in quality improvement and implementation initiatives to improve the care of older people.<sup>31</sup> The guide includes very useful information about change management principles; matching implementation strategies to identified barriers to change; Plan-Do-Study-Act cycles; monitoring and evaluation; and a good summary of the relevant literature. For the CC6 project, the general approach and resources should be applicable to a broad range of community aged care organisations. The [Valuing People](#) resource provides a checklist to guide organisations assess the extent to which they are person-centred, or relationship-centred, in terms of their approach to staff and clients.<sup>32</sup> Although originally conceived to improve person-centred care for those with dementia, the resources can be used for all types of clients without the need for external facilitation. Alzheimer's Australia (AA) has assumed responsibility for management of the Valuing People resource, and State and Territory AA organisations have been trained to support organisations undergoing the self-assessment process. There is potential for greater uptake of the resource, particularly as a means to supporting organisations in delivering client centred care which is at the heart of the Consumer Directed Care reforms. The resource is currently being trialled on a small scale in residential aged care, and any further development and/or promotion of the resource would best be considered after this has been completed. The resource can be accessed on the Alzheimer's Australia website.

## 6.2 Community projects

Five projects (CC1, CC2, CC3, CC4 and CC5) took a multi-level approach aimed at improving client outcomes. The evidence from the diffusion of innovations literature is that certain

<sup>31</sup> Australian Health Ministers Advisory Council (AHMAC) (2008) [The 'how to' guide: Turning knowledge into practice in the care of older people](#), Victorian Department of Health, Melbourne Australia [www.health.vic.gov.au/acute-agedcare](http://www.health.vic.gov.au/acute-agedcare)

<sup>32</sup> Alzheimer's Australia (2014) [Valuing People Resource kit](#) <http://valuingpeople.org.au/>

characteristics of innovations can influence whether they will be taken up and implemented elsewhere: relative advantage (the degree to which the innovation is better than what is in place already); compatibility (the innovation is compatible with the values and perceived needs of the adopting organisation); complexity (the innovation is relatively simple); trialability (the innovation can be 'tried out' before full adoption); observability (the benefits of the innovation are visible); adaptability (the innovation can be adapted for local use); risk (the innovation is perceived as low risk).<sup>33</sup>

Based on these seven 'characteristics of innovations', there are some favourable indications that the innovations developed and implemented by the five projects have the potential to be adopted more broadly:

- Relative Advantage: the innovations align with consumer directed care reforms.
- Compatibility: the innovations are compatible with the needs and values of aged care.
- Complexity: each project involved small changes in service provision to clients and, in general, the resources developed by each of the five projects were simple to use.
- Trialability: the innovations lend themselves to being 'tried out' on a relatively modest scale.
- Observability: each of the five projects resulted in examples of staff 'seeing the benefits' of the changes that were occurring.
- Adaptability: the innovations can be adapted for local use, which may require adapting training materials to suit the learning needs of staff.
- Risk: the innovations are low risk.

There is one issue which limits the generalisability of the findings from the five projects, concerning complexity. Although the practice changes implemented by each project were relatively small in scale that does not mean that implementing those changes successfully is easy, as demonstrated both in this round and the earlier rounds of the program. The findings from the evaluation indicate that several factors are likely to influence the ability of other organisations to adopt and implement these innovations. Staff will need the ability to engage with clients and understand the change being proposed; there will need to be support from managers, peers or someone in a designated position to facilitate the changes; and staff will need some way of working out how to incorporate the practice changes in the work they are doing already.

Without the relative advantage provided by supporting the implementation of CDC, there would be limited incentive for organisations to implement the project outcomes. For example, there are no demonstrated improvements in client outcomes mostly because of the poor reporting of client outcomes by a couple of projects. Furthermore, none of the projects demonstrated the cost effectiveness of what was implemented.

Specific comments about the generalisability of each project, including relative advantage, are summarised in Table 27.

<sup>33</sup> Greenhalgh T, Robert G et al. (2004) *Diffusion of innovations in service organizations: systematic review and recommendations*. *Milbank Quarterly*, 82 (4): 581-629.  
Rogers, E. M. (2003). *Diffusion of innovations*, 5th edition. New York, Free Press.

**Table 27**      *Generalisability – community projects*

Project	Comments about generalisability
CC1	<p>The client education resources are suitable for those who are fluent in English and have no cognitive impairment. These materials require revision before widespread dissemination can be contemplated.</p> <p>There is some evidence of a favourable impact on clients but both the leg ulcer and skin awareness programs require further work to improve effectiveness.</p> <p>The use of DVDs for client education ensures consistency in the information provided to clients and lends itself to wider implementation, but requires ongoing funding to purchase (and replace) DVDs and DVD players.</p>
CC2	<p>There is some evidence of a favourable impact on clients but no evidence of an increase in client activity.</p> <p>With its focus on incorporating social and recreational goals in care planning, this project potentially fits well with the broader agenda of consumer-directed care (CDC); similarly, by aiming to increase client activity the model aligns to the wellness and re-enablement focus of aged care reforms. As long as local conditions are favourable (e.g. resources to support the change in practice, support from local management) the principle underpinning LEAP has wide applicability.</p> <p>LEAP champions were an important feature of this project and would require funding if this component of the model was employed elsewhere.</p>
CC3	<p>The project demonstrated a positive impact on client mood but was focused on a particular client group (elderly people with a Chinese background). The model is potentially generalisable to other groups with a culturally or linguistically diverse background but is relatively resource intensive, particularly the time taken to produce CDs and song books.</p> <p>CDs now represent 'old' technology – adoption of this model in other settings might benefit from the use of MP3 players.</p> <p>Care needs to be taken to ensure that the copyright of performers is not infringed, which can be partly overcome by employing a music therapist (music therapists can copy music).</p> <p>The model enables services to be more client focussed, thereby potentially fitting well with the broader agenda of CDC.</p>
CC4	<p>Clients perceived an improvement in the quality of case management.</p> <p>Of the three groups targeted by this project (Greek, indigenous, rural/remote), Greek clients benefited the most. This suggests that the intervention may be more suitable for some groups than for others.</p> <p>With its aim of increasing client involvement in decision-making about their own care, this project fits well with the broader agenda of CDC. The model relies on clients' willingness to allocate part of their 'care budget' to pay for case management, which may limit uptake of the model more broadly.</p>
CC5	<p>The project final report includes no evidence to support the claim of improvements in client outcomes.</p> <p>The clients enrolled in this project were given priority access to dental care. The extent to which this access to dental care contributed to the overall results achieved by this project is not known but is likely to be considerable. Similar results may not be achieved elsewhere without the same priority access to dental treatment.</p> <p>There was a strong emphasis in this project on facilitation, primarily from the project team but with the support of a local staff member dedicated to work half-time (0.5 FTE) in this role. Without this level of support, similar results are unlikely to be achieved elsewhere.</p>

### 6.3 National roll-out projects

The focus of these two projects was to actively disseminate evidence-based resources about palliative care and wound care throughout residential aged care i.e. they are both exercises in promoting generalisability. The two issues regarding generalisability which arise from these projects are about their capacity to be implemented. Although there was widespread dissemination of the resources and processes by each project, it is not clear that these have been integrated into practice. For example, a recurring theme in the CSI stakeholder interviews is concern about the potential cost of best practice wound care products that may be a barrier to ongoing implementation. Data in the RC1 final report shows that while some processes appear to have been implemented (increased number of Advance Care

Plans), the system level impacts have not changed, in terms of transfers to hospital, place of death and ACFI claims.

The *Guidelines for a palliative approach in residential aged care* provided the foundation for the RC1 project. We are aware that both the *Guidelines* for residential aged care and those for community care services are currently being updated. Once these have been completed, the *Palliative Approach Toolkit* will need to be updated. It is not clear that a similar 'roll-out' of the updated guidelines will change behaviour, or whether some other mechanism should be employed to assist/encourage aged care organisations to embed the palliative approach in practice.

The *Champions for Skin Integrity Guide and Resource Pack* has likewise been disseminated throughout residential aged care and early indications suggest that many aged care services have reframed their processes and practices accordingly. There are some elements of overlap in terms of content of RC2 and CC1, which targeted community care clients and services. The evidence base of the RC2 covers a broader and wider spectrum of wound management issues than the CC1 project and therefore may provide ready transferability to community care services. Any consideration of improving skin integrity and wound care within the community care sector would need to consider the potential for integration of resources, tools and processes between the two projects.



## 7 SUSTAINABILITY

It is widely agreed that sustainability of an innovative project encompasses three important elements:

- Maintaining the benefits of the project for consumers and other stakeholders;
- Continuing some activities of the project, consistent with its original goals and objectives;
- Building capacity in the system or the community to continue the project.

This broad definition of sustainability is based on two major reviews of the literature.<sup>34 35</sup> Sustainability is more than simply what remains after program funding ends. Instead, it is generally seen as an ongoing process that needs to be integrated into project planning and throughout implementation.<sup>36</sup> Implementation processes such as stakeholder engagement, staff participation, adaptation of project activities to meet organisational needs and dissemination of materials all contribute to sustainability. Activities specific to sustainability include the use of policies and rules to standardise project activities and integrate them into 'business as usual', and obtaining and maintaining resources such as staff, equipment and training materials.<sup>37</sup>

In this section of the report, we consider the sustainability of the 11 EBPAC projects using the definition above as a framework. That is, to what extent will the projects' benefits and activities continue, and what capacity has been established to support sustainability? We draw on projects' final and progress reports and the key stakeholder interviews conducted by the national evaluation team. In addition, Evaluation Tool 4 included an item asking respondents to 'identify any issues that may challenge the future sustainability of the training materials'.

### 7.1 Factors that promote sustainability

In measuring sustainability, it is important to decide which aspects of the innovation are expected to be sustained, and in what form.<sup>38</sup> Furthermore, it is vital to consider characteristics of the innovation itself, including evidence of effectiveness,<sup>39</sup> and whether it meets the needs of intended users and is compatible with their philosophies and agendas.<sup>40</sup> Each of the EBPAC projects was informed by evidence such as clinical guidelines, literature reviews etc. (see Table 4). Local contextual factors, such as client needs, staff attitudes, and organisational strategic directions were explored through engagement and consultation

<sup>34</sup> Shediach-Rizkallah MC and Bone LR (1998) *Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy*. *Health Education Research*, 13 (1): 87-108.

<sup>35</sup> Scheirer M (2005) *Is sustainability possible? A review and commentary on empirical studies of program sustainability*. *American Journal of Evaluation*, 26: 320-347.

<sup>36</sup> Pluye P, Potvin L and Denis J-L (2004) *Making public health programs last: conceptualizing sustainability*. *Evaluation and Program Planning*, 27: 121-133.

<sup>37</sup> *ibid.*

<sup>38</sup> Stirman S, Kimberly J, Cook N, Calloway A, Castro F and Charns M (2012) *The sustainability of new programs and innovations: a review of the empirical literature and recommendations for future research*. *Implementation Science*, 7: 17-35.

<sup>39</sup> Pluye et al, *op cit*

<sup>40</sup> Johnson K, Hays C, Center H and Daley C (2004) *Building capacity and sustainable prevention innovations: a sustainability planning model*. *Evaluation and Program Planning*, 27: 135-149.

with key informants, which in turn provided an indication of the extent to which the project would meet a receptive context. These two foundational elements – evidence and context – when well facilitated, are widely understood as leading to successful implementation of research into practice.<sup>41</sup>

Whether implementation is sustained is further influenced by a number of other factors, including:

### **Organisational factors, such as culture, leadership and policies:**

New programs are more likely to thrive and survive if implemented by organisations that are stable, mature and have a clear purpose, and by leaders who have a good understanding of program theory and are able to enlist community support.<sup>42</sup> Policies that formally establish the innovation as part of (new) usual practice have been shown to support the sustainability of project activities and benefits.<sup>43 44</sup>

### **Capacity, including funding, champions, staff skills and stakeholder investment:**

Capacity to sustain innovation is enhanced by the presence of multiple ‘champions’ at various levels of the organisation.<sup>45</sup> Another major contributor to capacity is a skilled, highly motivated and stable workforce.<sup>46</sup>

### **Processes, such as shared decision making, training and partnerships:<sup>47</sup>**

Ongoing support and collaboration among stakeholders has also been shown to influence the likelihood of sustainability,<sup>48</sup> along with formal linkages and established partnerships between organisations.<sup>49</sup> A supportive social and political climate is also likely to contribute to sustainability.<sup>50</sup>

In the next parts of this section, we consider the extent to which these three factors to promote sustainability were present in the EBPAC projects. As will become apparent, the leadership and change projects focussed on sector development initiatives and therefore are not included within discussions about sustainability at the organisational, staff and client levels.

<sup>41</sup> Alison Kitson A, et al (1998) Enabling the implementation of evidence based practice: a conceptual framework *Quality in Health Care* 7 : 149–158

<sup>42</sup> Harvey G and Hurworth R (2006) *Exploring program sustainability: identifying factors in two educational initiatives in Victoria*. *Evaluation Journal of Australiasia*, 6 (1): 36-44.

<sup>43</sup> Johnson K, et al, op cit.

<sup>44</sup> Stirman S, et al, op cit.

<sup>45</sup> Johnson K, et al, op cit.

<sup>46</sup> Stirman S, et al, op cit.

<sup>47</sup> Stirman S, Kimberly J, Cook N, Calloway A, Castro F and Charns M (2012) *The sustainability of new programs and innovations: a review of the empirical literature and recommendations for future research*. *Implementation Science*, 7: 17-35.

<sup>48</sup> *ibid.*

<sup>49</sup> Johnson K, et al, op cit.

<sup>50</sup> Harvey et al, op cit.

## 7.2 Sustaining benefits for consumers and stakeholders

### 7.2.1 Sustaining community care project benefits

Five of the six community care projects aimed to influence client behaviours or client outcomes directly and therefore might be expected to have some sustained benefits for individual consumers. For example, clients enabled to have greater involvement in decision-making about their care in CC4 are likely to continue to be able to use their newly acquired skills and processes in an ongoing manner. Clients who received support from CC1 would expect to have their leg ulcer healing and skin health improved and those who received priority dental therapy within CC5 would have their treatments completed; however, should these issues or needs recur outside of the project delivery, it is unclear whether these improvements would be sustained. Despite CC1 and CC5 demonstrating positive impacts of the education, such as increased knowledge, changes in relevant self-care behaviours, and increased self-efficacy, confidence and quality of life, it is unclear whether these will continue in the event the initial problem recurred after the project has finished. CC2 involved home care workers helping clients to set recreational and social goals and incorporate potentially beneficial activities (e.g., music, reminiscence, play, physical activity) into usual care. In CC3, one specific recreational activity (music listening) was targeted. Both these projects demonstrated improvements for clients, such as increased engagement, reduced agitation and apathy, and better mood and there is no reason to expect these outcomes to change if the activities continue. However, one interviewee noted that keeping clients interested over time was a challenge and that the education may be less suitable for those with dementia or limited mobility, or those without an informal carer (CC1\_3).

The training provided to staff to deliver the education/goal setting/music and the quality of resources provided are key factors impacting on sustainability. For CC1, most of the changes to knowledge and behaviour were retained by staff at 12 weeks following the intervention. For CC5, the provision of accessible materials to clients (bathroom prompts, booklets and, to a lesser extent, online resources) was expected to assist in retaining knowledge and maintaining self-care, however this not supported by evidence in the final report.

For CC2 and CC3, sustainability of benefits relies on continuation of project activities (which is discussed further below). It also relies on appropriate targeting of those activities, as some clients may prefer a more task-focused service. Stakeholders interviewed by the evaluation team for CC2 suggested that LEAP was less suitable for perhaps 20% of clients who already had busy social lives or placed less priority on lifestyle goals (CC2\_3, CC2\_4). As noted in the CC3 final report, it may be necessary to vary project activities somewhat (e.g., occasionally updating the playlist of music provided to clients, or reviewing their goals) in order to maintain clients' interest and engagement. There are promising signs that clients, family carers and home care providers are taking the initiative to continue project activities by using their own devices to search the internet for additional music to supplement the tailored CDs produced by CC3 project staff.

All five community care projects aimed to change the knowledge and behaviour of aged care providers including nurses, case managers, home care workers and personal carers. Participants in CC1, CC2, CC4 and CC5 received training and support to enable them to deliver education to clients and/or incorporate new practices (e.g., leg ulcer compression

bandaging, skin health monitoring, recreational goal setting, and oral health assessment) in usual care. Two projects (CC1, CC5) were able to demonstrate positive impacts on providers' skills, understanding or attitudes, and two others (CC2, CC3) showed increases in job satisfaction. Staff turnover is, of course, a risk for all projects that involve training; however, building capacity among staff members has been shown to contribute positively to the sustainability of project activities.<sup>51 52</sup>

### 7.2.2 Sustaining national roll-out project benefits

While both RC1 and RC2 were conducted similarly, the change management and sustainability was more explicitly built into the latter. RC2 was successful in targeting its workshops at more qualified and influential staff within the facilities (more than two-thirds of participants were registered nurses, nurse managers, educators or consultants) and the findings from pre- and post-surveys indicated increased confidence both in their wound management skills and their ability to facilitate change in their organisations. The inclusion of the change management components and the 'train-the-trainer' approach were deliberate strategies to enhance the uptake and sustainability of new wound management and skin care practices, guided by the resources. Although there were no implementation strategies directly targeted at residents, feedback from participating sites suggested there were some positive impacts such as reduced incidence of skin tears and greater comfort. For RC1, there was no specific action required on the part of workshop participants when they returned to their organisations and so change management efforts were dependent on the skills and motivation of the individuals involved. There was some adaptation of the resources to meet local needs. Consumer outcomes were not measured.

For both these national rollout projects, staff turnover is a risk to sustainability of benefits for providers, but this is ameliorated somewhat by the availability of high quality resources distributed to all residential aged care facilities across Australia (and, for RC1, on the CareSearch website). Sustainability of the benefits for consumers (RC2 only) will depend on how successful project 'champions' are in establishing the new practices as part of usual care in their organisations. In theory, the workshop training in change management has equipped them with the skills and knowledge they will need.

## 7.3 Continuing the activities

### 7.3.1 Continuing the activities of community care projects

Several community care projects have indicated in their final reports that staff who were trained will continue to use their new skills in their daily encounters with clients. Health workers who undertook the SAP training (CC1) will continue checking clients' skin and reporting problems to nursing staff; recreational and social activities such as reminiscing and music listening can be carried out while the care worker is doing housework or driving the client to an appointment (CC2). Delivery of preferred music listening will be taught to new home care workers as part of their induction procedures (CC3\_3). More than half the care packages delivered by the host organisation for CC4 are now based on the CDC model and there will be 'no turning back' (CC4\_2).

<sup>51</sup> Maher L, Gustafson D and Evans A (2003) *NHS Sustainability Model*. NHS Institute for Innovation and Improvement. Downloaded from: [http://www.evidenceintopractice.scot.nhs.uk/media/135265/sustainability\\_model.pdf](http://www.evidenceintopractice.scot.nhs.uk/media/135265/sustainability_model.pdf)

<sup>52</sup> Stirman et al, op cit.

In the medium to long term, staff members will need to take on responsibility for engaging new clients and carers in these programs. Empowering staff to take responsibility for implementing and sustaining change is another identified factor in sustainability (Maher et al., 2003). One goal of CC5 was to empower home care workers to broaden their focus beyond completing tasks (such as housework or shopping) to a more holistic view of caring for their elderly clients. The project aimed to give them greater awareness of oral health issues, the knowledge to make oral hygiene a part of routine care, and confidence to advocate for clients to have their problems addressed. Workers are also more likely to remember and prioritise new activities if they have high face validity (i.e., they are self-evidently useful) and they can see the benefits immediately (Maher et al., 2003). For example, CC2 reported that participating organisations had witnessed positive impacts on both clients and care workers. The project had:

*Changed a lot of minds in the organisation; LEAP provided a different mindset as to how to work with clients into the future. (CC2\_2)*

The challenge of changing minds should not be underestimated; CC4 stakeholders acknowledged some resistance from both staff and clients unused to the new ways of working. For example:

*Staff thinking that this was a project and that from 1 January they can revert back to the old way of doing things – there has been some resistance from case managers. The service manager comes from an accountancy background and not a care background. Looks at dollars and cents and not about the service itself. Took a long time to change his mindset. It is not so much about training it is a shift in philosophy. (CC4\_6)*

Changes to work patterns that make work easier and more efficient provide benefits to staff members, who are then invested in sustaining those changes (Maher et al., 2003). In the case of the community care projects, none actively sought to simplify or streamline work processes. However, in many cases the new tasks were not time consuming and did not require expensive resources, making it more likely they would be incorporated into ongoing practice. LEAP (CC2) was one such project where implementation was relatively easy and inexpensive; according to one interviewee, resources could be as simple as printing out a crossword (CC2\_5). This was not always the case, and continuing project activities in the absence of dedicated project time will depend on the motivation of individual workers:

*In the program, RDNS gave staff extra time to carry out the 10 week project with clients. This is not possible outside of the project, after program there is simply no time to work closely with clients on this issue alone. But it has built good working habits. (CC1\_1)*

*Without the project, there is nothing to incentivise staff to continue. (CC1\_7)*

*We ask such a lot of our care workers...everyone is so busy. (CC5\_2)*

Lack of specialised resources may be a barrier to sustainability for some of the community care projects. For example, the LUPP component of CC1 will continue in its original form at the Victorian regional sites only as long as the kits are available (100 kits were put aside for their use). The LUPP kits cost \$113 each, not including the DVD, health worker and participant booklets, and it is unclear whether further money will be available to replenish the supply. The kits have been made available via an external supplier, Independence

Australia, used by clients of RDNS. The booklets, DVD and self-directed learning package will require updating from time to time. The CC3 final report acknowledges that producing tailored music collections and songbooks for individual clients is a time-consuming process that may not be feasible without EBPAC program funding. The cost of providing the CDC model, with access to a choice of services, varies according to whether the client lives in a suburb or a rural location (CC4\_1, CC4\_9). Funding will be required to update the CC4 training resources regularly and meet the costs of web hosting.

Project activities may be sustained in some form if they can be adapted in response to evaluation findings, stakeholder feedback or organisational needs.<sup>53</sup> For instance, the most effective aspect of the SAP project (CC1) was the education of health workers. Nevertheless, client education was seen as important, and therefore other options for communicating the importance of skin health maintenance to older people (e.g., stand-alone delivery; peer education) have been explored and are being considered for the future. The evaluation also provided useful information to guide improvements to some of the LUPP (CC1) activities and sessions to enhance effectiveness. If it proves impractical to create a tailored music collection for each client, the CC3 project can draw on its existing library to develop more generic CDs that meet clients' preferences for artists or genres.

### 7.3.2 Continuing the activities of national roll-out project

The main activities of RC1 and RC2 were workshops for large numbers of participants and distribution of the resource kits nationally. While these are now complete, it is reasonable to expect that some form of ongoing training will be facilitated at the local level through the skills and resources provided to participants as part of the workshops. The Palliative Approach toolkit will continue to be accessible on the CareSearch website, the main repository of palliative care resources nationally; however, the extent to which aged care staff access the site is unclear. Updating resources will require additional funding; RC2 will need to seek funds to conduct evidence reviews every two to three years and to continue disseminating the CSI toolkit.

## 7.4 Continuing the new processes

The capacity for organisations to sustain change is very much influenced by systemic factors at the organisational, broader sector and societal levels. For example, formal linkages among organisations tend to underpin the success and sustainability of projects.<sup>54</sup> In this respect, the EBPAC projects had a strong foundation for sustainability, as their contracts required a consortium approach. Partnerships were established at the beginning of the program, with a commitment to change and clear expectations for the contribution from each participating organisation. This approach has numerous advantages for implementation, including establishing shared understandings of the purpose and methods of the project, minimising barriers and ensuring access to necessary expertise and resources.<sup>55</sup> Similarly, the wider political and social climate can either support or undermine the sustainability of innovative programs.<sup>56</sup> The inclusion of key stakeholders in governance

<sup>53</sup> Stirman et al, op cit.

<sup>54</sup> Johnson et al, op cit.

<sup>55</sup> AHMAC How To Guide, op cit

<sup>56</sup> Harvey et al, op cit.



arrangements is one means to ensure the projects are aligned with contemporary developments.

To be sustainable at a system level, programs need to be accepted by stakeholders and integrated into organisational practice. At the same time they need to be supported by adequate infrastructure and resources.<sup>57</sup> All the EBPAC projects aimed to make system-level changes to increase the use of evidence to drive improvements in aged care services. Project documents reveal a high level of awareness of the need to build capacity in the system (i.e., within and among organisations) to sustain these changes. Projects employed a range of strategies to address system-level factors known to contribute to sustainability.

#### 7.4.1 Continuing the processes of leadership and change projects

Building capacity in the system to promote and sustain evidence-based practice was the main focus for the two leadership (CL1, CL2) and two organisational change (RC3, CC6) projects. These projects exhibited some of the features of sustainable innovations, discussed above. CL1, CL2 and RC3 used an action research approach which empowers participants to drive changes in practice. Participants were supported by change champions, clinical mentors or workshop facilitators. Partnerships were built among participating organisations, and training materials, assessment tools, guidelines and evaluation outcomes were shared, providing evidence to drive and embed change in organisational policies and procedures.

For CL1, training was carefully targeted at highly motivated and influential individuals, guided by a tool designed to assess leadership potential. The project's final report acknowledged that the commitment required by organisations was considerable, but the 'benefits were commensurate' (p. 6). CL2 also relied on the selection of suitable mentors and site champions to initiate and sustain changes in practice. Champions need to be recognised by their peers as experts, and to demonstrate leadership. Seven attributes of successful mentors were identified in the focus groups. In addition to demonstrated leadership ability and expertise in the project area, mentors required high-level interpersonal and communication skills, research translation expertise, and the ability to network with other mentors, to assess the needs of trainees and design appropriate training methods, and to evaluate their own work. The final report also noted that mentors had to act as advocates, negotiating with management to release workers for training and to include evidence-based materials in daily practice. The question of how to fund such expert and experienced staff inevitably arises. In the case of CL2, two participating organisations have decided to continue the role. At the first site, the residential care management role was restructured to create three clinical nurse positions, one of which is dedicated to clinical mentoring. At another site, a clinical nurse position (with a strong emphasis on clinical mentoring in the job description) has been created in the clinical priority area addressed during the project. There are signs that other organisations are considering business cases for the role.

Nevertheless, the cost of employing clinical mentors represents a serious challenge to the sustainability of CL2. Clear guidelines and expectations around the mentor's responsibilities will be required, and they will need to continue demonstrating the value of the mentor role

<sup>57</sup> Johnson et al, op cit.

to their organisations, using data to show impacts on practices and outcomes. This will mean ensuring that individual projects are consistent with the organisation's strategic directions for continuous quality improvement, thus maintaining a steady flow of resources, adequate infrastructure and management support. For CL1, demonstrating benefits and maintaining management support will require project champions to keep bringing the focus back to the leadership capacity being built, as well as the action learning outcomes themselves.

Both CL1 and CL2 produced educational materials, which will need to be embedded in organisational training strategies and methods to be sustainable. Sustainability of the CL1 training materials could be promoted by linking the content to 'accredited units of training under the Australian Quality Training Framework'; while this was specifically excluded under EBPAC funding agreement, the alignment of competencies to the Industry Skills Council enhances both the generalisability and sustainability of the model.

The key to sustainability of both RC3 and CC6 is dissemination and uptake of the resources developed. RC3 created a toolkit of five tools designed to guide work teams through action research processes in order to address workplace challenges and promote change. The resources are highly flexible and could be applied more widely than the aged care sector. The sustainability plan involves making the toolkit, including guides for work teams and leaders and additional resources, available online on the WACHA website. They could then be printed and used freely. This strategy is unlikely to be sufficient without some sort of active promotion (as acknowledged in the project response to Evaluation Tool 4). At the time of writing, the project team was planning to present the resources to the Aged Care Standards Accreditation Agency and the Dementia Training Study Centres in the hope that these organisations would promote the toolkit as a quality improvement resource.

Although RC3 incorporated many aspects of a sustainable innovation, including drawing on the evidence base in its design, addressing issues relevant to each organisation, engaging the support of project partners and ensuring senior managers were behind the project, the impacts of the project on participating organisations were unclear. The case for sustainability would be strengthened by clearer evidence of benefits but these were not available from the evaluation activities (organisational and staff surveys). Further, it was clear that project officers provided considerable hands-on guidance to work teams implementing the toolkit, especially during Cycle 1 when they attended the first two meetings, the final meeting and any other meetings as needed. Less support was given during Cycle 2 in an effort to encourage independence, but project officers were available when required. It is hard to imagine how the toolkit could be implemented and work teams' activities sustained (in the face of many competing pressures) without this source of encouragement and expertise.

The *Valuing People* document and website (CC6) were evidence-based and consistent with the Australian Government Living Longer Living Better policy directions. There was extensive consultation with consumer groups during development but aged care industry representatives were less involved. The resources will be hosted, maintained and (presumably) updated by the national office of Alzheimer's Australia but a national strategy for engaging state offices and industry peak bodies is required. The original sustainability



strategy involved Alzheimer's Australia, through its State and Territory offices, undertaking a paid consultancy role with aged care providers to provide training in how best to implement the resources within their organisations. At the time of writing, this was in its infancy; one consultancy was being negotiated with a single Victorian provider. Further, it appears that the resources will be made available online and can be used without training, or with the assistance of a series of tutorial videos that are currently being developed. Organisations that do not feel confident to implement the resources without formal training can approach Alzheimer's Australia for support. These arrangements would appear to close off the consultancy role as a potential source of revenue. Stimulating uptake of the resources will be a challenge, given that the project was unable to demonstrate positive impacts within its timeframe. However, its capacity to demonstrate organisational alignment with the aged care reforms, particularly CDC, is still a key enabler.

#### 7.4.2 Continuing the processes of community care projects

The use of organisational policies and procedures and alignment with quality improvement systems was common amongst the five community care projects that introduced new ways of delivering care to clients. As discussed above, there are promising signs that the project activities will continue in some form. Several projects reported that the new activities were now part of usual practice; for example, incorporating social and recreational goals into clients' admission documentation and care plans and making LEAP an item on staff meeting agendas (CC2); offering preferred music listening as part of existing home care packages (CC3); or distributing leg ulcer kits via the organisation's equipment supplier (CC1). These measures provide a mechanism for supporting and reminding staff, which is necessary to ensure project activities are not overtaken by competing priorities or squeezed out by demands for greater efficiencies (e.g., as highlighted in CC4, reductions in case manager/client ratios may mean there is less time to spend with consumers). Ideally, organisations would continue to assess outcomes and communicate progress to staff and leaders (Maher et al., 2003); however, there is no indication in projects' final reports that this kind of ongoing monitoring is planned.

The use of influential leaders and champions was a strategy also employed by several of the community care projects. The CC5 final report notes that minimal investment in staff development is characteristic of the home care sector, and home care workers themselves have little incentive or opportunity to undertake further education. Despite this, they found that the workers could be 'enablers' of the oral health program, given their established knowledge of, and relationships with, their clients. Oral health and hygiene issues can be personal and sensitive and therefore a level of trust is required in order to discuss these subjects. Qualitative findings from the evaluation demonstrated that home care workers themselves were well aware of these sensitivities. Not only were they using their new knowledge with the clients, they had begun to share it with family and friends, taking a wider 'champion' role than first envisaged.

Champions were an important feature of CC2. Five champions were employed (0.2 FTE) to drive change and support case managers adopting the LEAP model of care. It was found that this model worked best when the champion was a staff member at that site; working across geographical locations created difficulties with acceptance by other staff members, as well as travel and logistics. In addition, champions were most effective when backed by supportive managers; this was especially important if a champion was absent or unable to

carry out their tasks for some reason. In CC5 the role of ‘dedicated facilitation’ of project activities was recognised as a key contributor to their uptake and sustainability in the participating organisations. Facilitation was seen as more than project management:

*It was recognised as a distinctive role which required a sophisticated range of knowledge and skills, including the ability to boundary span across the multi levels within organisations plus traverse across sectors (CC5 Final Report)*

It should be noted that each home care provider released a staff member (0.5 FTE) for the duration of the project to enable this facilitation to take place, and it is unclear whether this staffing support will continue beyond the end of the EBPAC program.

The reliance on project funds or partnership agreements that terminate when program funding ends to pay for project champions raises a wider issue around continuation of resources. The CC5 project requires home care providers to invest in training of their workers, although at an average of two hours in total (usually delivered as two, one-hour sessions facilitated by a trainer) this does not seem an onerous financial burden on the participating organisations. Two of the community care projects were designed to run within usual budgets (CC2, CC3). CC4 relies on clients’ willingness to pay for case management, which naturally creates pressures to ensure it provides value for money (CC4\_4). In some of the community care projects, home care staff were expected to attend training in their own time; it is questionable whether asking low-paid workers to subsidise a program in this way is sustainable (or indeed ethical).

An example of how strategic partnerships can promote sustainability is available from the SAP component of CC1. As discussed above, client education proved time consuming and resource intensive, but was considered an essential part of promoting skin care and health. Members of the stakeholder advisory group suggested that peer education might be a more efficient way to disseminate this information to elderly people. As a result, the project team and Council on the Ageing put together a successful proposal for funding to develop and evaluate a peer education model.

The wider political and social climate proved to be used to great effect in facilitating the systemic embedding of changes within participating organisations. This is particularly relevant for the community care projects, which tap into prevailing philosophies around the desirability of holistic and consumer-directed care. CC1 and CC5 recognised that home care services could do more than attend to house work and shopping; their regular contact and established relationships with older people provide opportunities for timely and appropriate health promotion activities as well. CC2 and CC3 broadened the focus further to include simple measures that might boost elderly people’s social and emotional well-being. CC4 developed tools and trained the aged care workforce with the ultimate goal of empowering clients to plan their own care packages wherever possible. The design of CC4 is consistent with Australian Government aged care reforms which mean that by July 2015 all aged care packages will have a CDC focus. The CHOICES model is seen by some community providers as a promising way to prepare their service models for the CDC approach.

CC5 illustrates how the policy context and wider environment can both help and hinder a project. This project fitted neatly within national aged care and dental reforms, which emphasise ageing well at home. According to the project's final report

*This gave a credible sense of purpose uniting the participating dental providers and home care organisations to engage in efforts to improve older people's oral health.*

Nevertheless, the project faced a major barrier in the form of the historical disconnect between home care and dental services. This was overcome temporarily through a partnership agreement under which public dental service providers agreed to give priority to clients referred via the project as an 'in kind' contribution. However, more lasting arrangements and a greater visibility of the home care sector within health will be needed to promote sustainability of the oral health initiatives.

### 7.4.3 Continuing the processes of national roll-out projects

RC1 and RC2 did not seek to influence practice directly and hence had no immediate power to alter organisational policies or procedures to enhance sustainability. Instead, they used the strategy of selecting and educating champions to lead these changes in their own workplaces. By focusing on influential clinical leaders (e.g., nurse educators and nurse consultants in RC2) and training multiple champions across different parts of an organisation, these projects have enhanced the likelihood that any impacts will be sustained.<sup>58</sup> There are some indications that this strategy was successful; for example, of the workshop participants who reported back to RC2, many represented large organisations with multiple sites and care settings. Sustainability strategies employed by these workshop participants included conducting research with the CSI resources; integrating the resources into policies and procedures, e-learning portals, e-pathways and/or organisational intranet materials; and gaining support at high levels of the organisation (such as the board) to consider CSI in governance and planning. For RC1, the workshops resulted in the PA Toolkit being incorporated into the models of care, policies and procedures of several large residential aged care providers and individual facilities, such as Blue Care, TriCare, Uniting AgeWell, Churches of Christ Care and LHI Retirement Services. In addition, the model of care underpinning the PA Toolkit has been adapted for community aged care (under the Decision Assist project).

Extra funding from the Department of Health has enabled RC1 to produce additional resources for care workers in residential aged care settings, based on the PA Toolkit resources. These are expected to be available in late 2015. In Brisbane, clinical education sessions will be delivered to local RACF staff to support their use of the PA Toolkit. A specialist palliative care nurse has been employed to deliver the workshops and other support to the 75 RACFs in the MSPCS catchment.

<sup>58</sup> Johnson et al, op cit.

## 8 DISSEMINATION

This section reports on dissemination activities undertaken by projects and includes data from nine dissemination logs from 11 projects submitted between November 2012 and July 2014. A total of 197 dissemination activities were recorded.

### 8.1 Type of dissemination

Project officers were asked to record type of dissemination, the purpose of the dissemination, whether they received any follow up contact about the activity and how they rated the effectiveness of the activity.

Type of dissemination included a range of activities such as stories published in newsletters or newspapers, information provided on a website or via an email list, presentations at conferences, radio and television interviews or advertising, brochures or pamphlets and peer reviewed journal articles. An outline of the most commonly reported dissemination activities are included in Table 28 below, including the number of these activities undertaken and the proportion they represent of all dissemination activities. The five most commonly recorded activities included:

- A story in a professional or industry magazine or newsletter
- Information provided on a website
- Presentation at a national or state/territory or local conference
- Story in a local magazine or newsletter
- Brochures, leaflets or posters in a health and community setting

Those activities least used by projects included television interviews, media advertising and radio advertising.

**Table 28** Type of dissemination by number and proportion

Type of Dissemination	Number	%
Story in a professional or industry magazine or newsletter	19	9.6
Information provided on a website	19	9.6
Presentation or poster at a national conference	19	9.6
Presentation or poster at a State/Territory conference	17	8.6
Story in a local magazine or newsletter	14	7.1
Presentation or poster at a local conference	14	7.1
Brochures, leaflets or posters in health & community settings	10	5.1
Email communication to groups/lists	7	3.6
Project newsletter	6	3.0
Story in the local newspaper	4	2.0
Peer-reviewed journal article	3	1.5
Radio interview	2	1.0
Media advertising	1	0.5

Type of Dissemination	Number	%
Television interview	0	0
Other	62	31.5
Total	197	100

There was a large number of dissemination activities described as 'other' (31.5%). These activities were analysed and classified into additional categories. The five most common other categories described by project officers included:

- Education and information sessions for families, residents and interested persons
- Staff education and/or training sessions
- Presentation to an Advisory Group/Board or senior management group
- Reports such as a report to a Board or annual report segment or a report for a general audience.
- The sharing of resources with external organisations (e.g. other health service, local Council)

## 8.2 Purpose of dissemination

Project officers were asked to identify the purpose of the dissemination. Purpose for dissemination was described as:

- Dissemination for awareness - audiences are made aware of the development/innovation/deliverables/project details.
- Dissemination for understanding - the audience is provided with more detail about the development and are perceived as beneficiaries. In this case audiences are often targeted.
- Dissemination for action - this 'refers to a change of practice resulting from the adoption of products, materials or approaches offered by your project. These groups/audiences will be those people that are in a position to 'influence' and 'bring about change' within their organisations. These are the groups/audiences that will need to be equipped with the right skills, knowledge and understanding of your work in order to achieve real change<sup>59</sup>.

The majority of dissemination activities were described as dissemination for awareness (55.8%). An outline of the number the type of dissemination activities described by the purpose of the dissemination is provided in Table 29 below.

**Table 29** *Dissemination activities by purpose of dissemination*

Type of dissemination	Action	Awareness	Understanding	Not answered
Brochures, leaflets or posters in health & community settings	1	4	2	-
Email communication to groups/lists	-	4	3	-
Information provided on a website	-	9	11	-
Media advertising	-	-	-	1

<sup>59</sup> Harmsworth, S., Turpin, S, and TQEF Team (2001) *Creating an Effective Dissemination Strategy*

Type of dissemination	Action	Awareness	Understanding	Not answered
Other	19	23	25	-
Peer-reviewed journal article	-	2	-	-
Presentation or poster at a local conference	1	8	3	-
Presentation or poster at a national conference	-	16	4	-
Presentation or poster at a State/Territory conference	-	10	8	-
Project newsletter	2	6	1	1
Radio interview	-	1	1	-
Story in a local magazine or newsletter	1	8	-	1
Story in a professional or industry magazine or newsletter	-	17	-	-
Story in the local newspaper	-	2	2	-
<b>Total</b>	<b>24</b>	<b>110</b>	<b>60</b>	<b>3</b>

Those activities most commonly described as dissemination for awareness included:

- Presentation at a conference (national, state/territory or local) (n = 34, 30.9%)
- Other dissemination activity (n = 23, 20.9%)
- Story in a professional or industry magazine or newsletter (n = 17, 15.5%)
- Information provided on a website (n = 9, 8.2%)
- Story in a local magazine or newsletter (n = 8, 7.3%)

The next most common purpose of dissemination activities was dissemination for understanding (30.5%). Those activities most commonly described as dissemination for understanding included:

- 'Other' dissemination activities (n = 25; 41.7%)
- Presentation at a conference (national, state/territory or local) (n = 15; 25.0%)
- Information provided on a website (n = 11; 18.3%)

Dissemination for action was the least common purpose for dissemination (n = 24; 12.2%). Within dissemination for action, 'Other' dissemination activities (79.2%) were the major type of dissemination activity described. These mostly included disseminating information at a steering committee, advisory group or consortia meeting.

### 8.3 Follow up after dissemination

Projects were also asked to record incidences of follow up activity. Specifically they were asked 'Did anyone who heard about the project follow-up by seeking more information?' Approximately 75% of projects included an answer to this question. Overall, there was follow-up activity for just over 50% of dissemination activities recorded. A further quarter recorded no follow-up activity whilst another quarter did not answer this question. Table 30 provides an outline of activities that were followed up and those that were not.

**Table 30**      *Dissemination activities by follow-up received*

Type of dissemination	Not answered	No	Yes
Other	28	9	30
Presentation or poster at a national conference	0	3	17
Presentation or poster at a State/Territory conference	2	5	11
Information provided on a website	3	8	9
Presentation or poster at a local conference	1	4	7
Story in a professional or industry magazine or newsletter	1	9	7
Brochures, leaflets or posters in health & community settings	0	1	6
Story in a local magazine or newsletter	3	1	6
Email communication to groups/lists	4	1	2
Story in the local newspaper	0	1	2
Peer-reviewed journal article	0	1	1
Project newsletter	5	4	1
Radio interview	0	1	1
Media advertising	1	0	0
Newspaper article	1	0	0
<b>Total</b>	<b>49</b>	<b>48</b>	<b>100</b>

Of those activities that recorded follow up activity, those with the greatest amount of follow up included:

- Presentation or poster at a conference (national, state/territory or local) (n = 35; 35%)
- 'Other' dissemination activities (n = 30; 30%)
- Story in a magazine or newsletter (professional or industry or local) (n = 13; 13%)
- Information provided on a website (n = 9; 9%)
- Brochures, leaflets or posters in health & community settings (n = 6; 6%)

Those activities that did not receive follow up were similar to those that did receive follow up. These included 'other dissemination activities (18.8%), Story in a professional or industry magazine or newsletter (18.8%) and information provided on a website (16.7%). Many of these activities that did and did not receive follow-up also comprised a large part of all dissemination activities. Given the large number of projects that did not report on follow-up activity, results should be interpreted with some caution.

#### **8.4 Effectiveness of dissemination**

Effectiveness of dissemination was rated on a scale of 1 to 5, with 1 being least effective and 5 being most effective. Table 31 provides an outline of how projects rated the effectiveness of dissemination activities. Included is an average score for the effectiveness for each type of dissemination activity. Not all projects provided an effectiveness rating for dissemination activities. Approximately 69.5% (n = 137) of activities were rated and 29.4% (n = 58) did not

provide a rating. The effectiveness of these activities were rated by project officers and there may be some differences in how the effectiveness rating was interpreted.

**Table 31** *Dissemination activities by effectiveness rating*

Type of dissemination	1	2	3	4	5	Av. rating	Not answered
Peer-reviewed journal article	0	0	0	0	2	5	0
Brochures, leaflets or posters in health & community settings	0	0	1	1	5	4.6	0
Other	0	2	7	3	23	4.3	31
Story in a professional or industry magazine or newsletter	0	0	3	4	7	4.3	3
Story in the local newspaper	0	0	1	0	2	4.3	0
Project newsletter	0	0	0	3	1	4.3	6
Story in a local magazine or newsletter	1	0	2	0	4	3.9	3
Presentation or poster at a local conference	0	1	2	8	1	3.8	0
Presentation or poster at a State/Territory conference	1	0	7	5	4	3.6	1
Information provided on a website	2	4	5	4	2	3.2	3
Presentation or poster at a national conference	0	1	4	7	2	3.1	6
Email communication to groups/lists	1	0	0	2	0	3.0	4
Radio interview	0	0	0	0	1	1.0	1
Newspaper article	1	0	0	0	0	1.0	0
Media advertising	0	0	0	0	0	0	1
<b>Grand Total</b>	<b>6</b>	<b>8</b>	<b>32</b>	<b>37</b>	<b>54</b>	<b>3.9</b>	<b>58</b>

Those activities with an average rating over four included:

- Peer reviewed journal article (av. Rating = 5)
- Brochures, leaflets or posters in health & community settings (av. Rating = 4.6)
- Other dissemination activities (av. Rating = 4.3)
- Project newsletter (av. Rating = 4.3)
- Story in a professional or industry magazine or newsletter (av. Rating = 4.3)
- Story in the local newspaper (av. Rating = 4.3)

Those activities with the lowest ratings were newspaper article and radio interview. Given the small numbers involved in how many times some of these activities were recorded the result should be interpreted with some caution.

## 8.5 Summary

Those dissemination activities that were most likely to be used, followed up and considered most effective by projects appeared to be:

- Presentation at a conference (national or state/territory or local)
- Story in a magazine or newsletter (local, industry or professional)



- Information provided on a website
- Brochures, leaflets or posters in a health and community setting
- Peer reviewed journal article
- Project newsletter

The main purpose of dissemination activities was for awareness and understanding with relatively fewer activities aimed at promoting action.

## 9 DISCUSSION

This report has detailed the overall impact and outcome of the latest round of EBPAC projects, and raises important insights into facilitating evidence-based practice within a complex and increasingly competitive aged care sector.

### 9.1 What was achieved?

There is no doubt that the Australian Government has provided significant investment to improve the delivery of evidence-based practice for aged care residents. This latest round of EBPAC projects has involved several thousands of aged care workers nationally. It builds on the earlier EBPAC rounds which, at the time of writing that evaluation report, we noted was the 'most comprehensive, coordinated approach to implementing evidence-base practice in residential aged care' within Australia. The outcomes of these projects have been promoted widely through the Aged Care Quality Agency's Better Practice conferences and through its website.<sup>60</sup> The residential aged care sector has subsequently been systematically equipped with resource kits and training and consultancy initiatives derived from five of the thirteen Rounds 1 and 2 projects:

- Better Oral Health in residential aged care: 396 workshops were delivered nationally, with 4,885 people trained from 2,809 aged care homes, multi-purpose services and Indigenous flexible care services (2009-10)<sup>61</sup>
- Dementia Dynamics Toolkit: distribution of free toolkits to all residential aged care facilities, supported by the delivery of 30 workshops nationally (2014-2015)<sup>62</sup>
- Designing for People with Dementia: national consultancy services of environmental design experts that provided on-site education, assessment and advice to aged and health care managers and architects (2013)<sup>63</sup>
- Palliative Approach Toolkit (RC1 in this latest funding round): provided 61 workshops nationally attended by 2,824 health professionals
- Champions for Skin Integrity (RC2 in this latest funding round): provided 37 workshops nationally attended by 1,286 health professionals

Within this latest funding round, the reach has been extended to beyond residential aged care to include community care resulting in innovative, evidence-based models of service delivery being tested and evaluated. A more significant development, perhaps, has been the increasing recognition by the sector generally, and the Department in particular, of the need to address systemic factors that can facilitate the delivery of evidence-based practice. EBPAC Round 3 included funding for projects to explore leadership development and organisational change models (CL1, CL2, CC6 and RC3), and there appeared to be an increased number of projects explicitly using evidence based knowledge translation techniques to inform activities.

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<sup>60</sup> e.g., 'Towards Organisational Cultural Change' (RC3) at <http://www.aacqa.gov.au/education-programs/other-resources-1>

<sup>61</sup> <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/publications-articles/resources-learning-training/better-oral-health-in-residential-care-training>

<sup>62</sup> <http://www.dementiadynamics.com.au/>

<sup>63</sup> <http://dtsc.com.au/wp-content/uploads/sites/2/2015/03/Residential-Care-Flyer.pdf>

## 9.2 Program objectives

The combination of both Round 3 EBPAC and ACSIHAG projects within the evaluation reflects the synergies that exist between each program. The overall objective of both programs has been to achieve practice and evidence-based improvements for people receiving aged care services, staff providing those services, the aged care system and the broader community. Table 32 below provides a summary of how the objectives of the EBPAC and ACSIHAG programs were met, drawing on evidence from across the evaluation. The fourth column of the table highlights the relevant sections of the report containing the evidence to support the conclusions about whether or not the objectives were met. Both programs sought to deliver impacts and outcomes at three levels – client and carer; staff and organisations; and the broader system – and consequently neatly align with the CHSD evaluation framework used. The approach taken to making a judgement about the programs’ success, however, has shifted from that used previously. As we noted in our evaluation plan, the diversity of projects means that applying one set of criteria such as ‘key success factors’ or principles of practice change’ that resulted from our earlier EBPAC evaluation did not make sense. Instead, our focus was to unpack the model of change used by each project to ensure the elements were in place to best support implementation of evidence based practice.

**Table 32**      **EBPAC objectives**

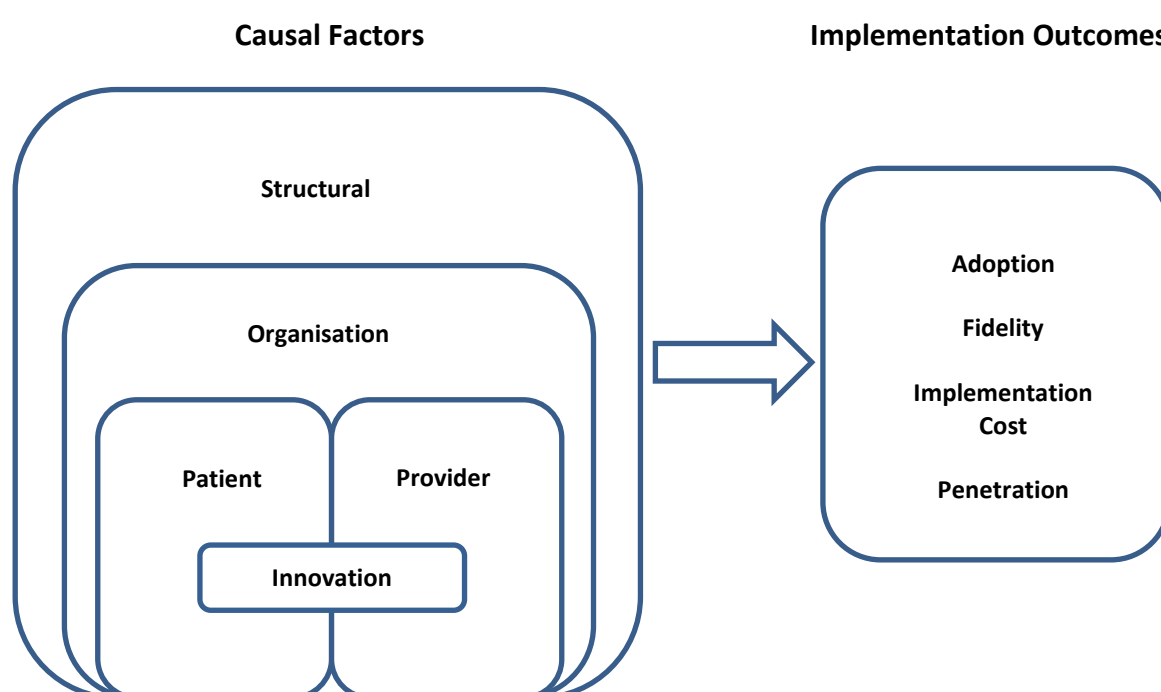
EBPAC or ACSIHAG	Objective	Evidence to support achievement	Ref. (Section)	Objective met or not met
Improvements for recipients of aged care services				
EBPAC	Improve clinical and personal care for recipients	All projects included application of evidence-based practice techniques and processes; however, there is limited evidence regarding client impact and outcomes	4.1	Objective met
ACSIHAG	Support activities that promote healthy and active ageing;	Social/leisure activities initiated and/or integrated into several projects; alignment of projects with CDC objectives.		Objective partially met
	Support activities that provide information and support to assist carers maintain their caring role;	Resources developed to assist carers support care and assess organisation culture.		Objective partially met
	Support to services providing aged care to Aboriginal and Torres Strait Islander people and people living in remote areas;	CDC and oral health resources developed; Oral health services and pathways		Objective met
	Support people from culturally and linguistically diverse (CALD) backgrounds.	Recreation activities initiated; CDC model clarified		Objective met
Improvements for staff				
EBPAC	Provide opportunities for aged care and health workforce to enhance their knowledge and skills to support the uptake of evidence-based, person centred, aged care practice	Each project involved education and training to staff in new evidence based practice	4.2	Objective met
	Support staff to access and translate the best available evidence into everyday practice;	Staff provided with evidence-based resources		Objective met
ACSIHAG	Support activities that build the capacity of aged care services to deliver high quality care.	Education and training provided, resource packages developed and disseminated		Objective met
System improvements				
EBPAC	Showcase innovative Australian evidence-based, person centred, aged care practice, including through encouraging partnerships between aged care providers, education and research organisations	Consortium approach to each project; Eight projects lead by / included research partners;	4.3	Objective met
	Widely disseminate and promote established, evidence-based, person centred aged care practice, including through encouraging partnerships between aged care providers, education and research organisations	Localised project activities limited the capacity for broader dissemination of many projects; partnerships expected to extend reach of dissemination.		Objective partially met
	Develop, maintain and promulgate resources that support	Initiatives aligned with strategic frameworks, competencies, and		Objective met

EBPAC or ACSIHAG	Objective	Evidence to support achievement	Ref. (Section)	Objective met or not met
	evidence-based, person centred, aged care practice and inform ongoing development of, and assessment against, relevant standards	standards.		
	Contribute to development of the aged care evidence base through evaluation of projects that translate into everyday practice	Each project included evaluation activities, some more detailed than others.		Objective partially met
ACSIHAG	Respond to existing and emerging challenges, including dementia care.	Leadership development, organisational change and organisational assessment projects		Objective met

### 9.3 The science of implementation

There is emerging evidence about the aspects of a model of change which are likely to work within different contexts, in particular the need to recognise the various factors or levels (the individual professional, the patient, the team, the organisation, the broader social context, the economic and political context as well as the innovation itself) that influence care outcomes.<sup>64</sup> This in turn requires a multi-level approach that is organised and planned, and engages relevant stakeholders in the change process.<sup>65</sup> The tools and frameworks developed to measure and predict the capacity of an innovation to succeed or fail increasingly recognise these inter-relationships and the consequent need to address the 'many moving parts' that impact on implementation.<sup>66</sup> (See Figure 4)

**Figure 4** A multi-level framework predicting implementation outcomes



Taken from: Chaudoir, S. et al, Measuring factors affecting implementation of health innovations; a systematic review of structural, organizational, provider, patient and innovation level measures, *Implementation Science* (2013) 8:22

The majority of evidence regarding implementation has been derived from the health system, which we applied to the residential aged care context in the form of 'key success factors'. These underpinned our earlier evaluation and the subsequent refinement into 'principles of practice change'; both of these developments align neatly with the multi-level framework outlined above.<sup>67 68</sup> The targeted literature review of community care knowledge

<sup>64</sup> Grol, R. and M. Wensing(2004) *What drives change? Barriers to and incentives for achieving evidence-based practice*, *Medical Journal of Australia*, 180 (6 Suppl) : S57-60

<sup>65</sup> Gordon, R et al (2013) *Evaluation of the Encouraging Better Practice in Aged Care (EBPAC) Initiative: Evaluation Framework*, Centre for Health Service Development, University of Wollongong p13

<sup>66</sup> Chaudoir, S. et al, *Measuring factors affecting implementation of health innovations; a systematic review of structural, organizational, provider, patient and innovation level measures*, *Implementation Science* (2013) 8:22

<sup>67</sup> Masso, M. McCarthy G. (2009) *Literature review to identify factors that support implementation of evidence-based practice in residential aged care*, *International Journal of Evidence-Based health Care*, 7 (2): 145-156

<sup>68</sup> Masso, M.et al (2011) *Encouraging Best Practice in Residential Aged Care Program: Final Evaluation Report*, Centre for Health Service Development, University of Wollongong.

translation activities (See Appendix 1) undertaken to inform this latest round of projects revealed additional factors that need to be taken into account, providing a variation on the above but with a more explicit focus on addressing the fractured and fragmented context of community care. These include a greater need for services to work in partnership and in collaboration, the need for the alignment of philosophical ideas and policies, organisational design factors that address administrative and clinical factors, and coordination and boundary spanning linkage mechanisms.<sup>69</sup>

Projects involved in implementing innovations therefore need to include a range of strategies and interventions to ensure the relevant factors are appropriately addressed. Table 33 summarises the interventions utilised by the projects, building on the Cochrane Effective Practice and Organisation of Care (EPOC) taxonomy of interventions known to be effective to improve health care systems and health care delivery.<sup>70</sup> These are discussed in more detail within the Project Delivery and Project Impacts sections (Sections 3 and 4).

**Table 33** *EBPAC projects and EPOC taxonomy of interventions*

Intervention	CL1	CL2	CC1	CC2	CC3	CC4	CC5	CC6	RC1	RC2	RC3
Educational materials distributed	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Educational meetings/ workshops	✓	✓	✓	✓		✓	✓		✓	✓	✓
Local consensus processes (action research, PDSA cycles)	✓	✓					✓	✓			✓
Educational outreach visits e.g. academic detailing			✓								
Local opinion leaders including 'champions' or 'mentors'	✓	✓	✓	✓			✓	✓	✓	✓	✓
Quality improvement processes e.g., audit and feedback	✓	✓	✓		✓		✓		✓	✓	
Collection of new clinical / care material		✓	✓	✓	✓	✓	✓	✓			
Reminders & prompts to recall information							✓				
Institutional incentives e.g. backfill, equipment	✓	✓	✓		✓	✓					
Revision of professional roles e.g. carer providing nursing care	✓	✓	✓	✓		✓	✓				✓
Introduction of multidisciplinary teams	✓							✓	✓	✓	✓
Changes to improve continuity of care (e.g., follow-up, pathways, case management)						✓	✓		✓	✓	
*Linkage, cooperation and communication with external services providers						✓	✓				

<sup>69</sup> Hollander and Prince (2008) *Organizing healthcare delivery systems for persons with ongoing care needs and their families: a best practices framework*, *Healthcare Quarterly*, 11 (1): 44-54

<sup>70</sup> Effective Practice and Organisation of Care (EPOC). Oslo: Norwegian Knowledge Centre for the Health Services (2015) <http://epoc.cochrane.org/epoc-specific-resources-review-authors>

*Philosophical and policy alignment e.g. model of care, CDC					✓	✓	✓	✓			
*Organisational readiness for change incl. administrative arrangements				✓		✓		✓			
*Coordination and boundary spanning linkage mechanisms						✓					

\* Particularly important for community care interventions

During the second national workshop project teams and members of their consortium and participating organisations were asked to reflect on a version of the above (minus the final four community care interventions) with the view to identifying what interventions worked best. Interestingly, in contrast to the evaluation team summary above, all ten projects in attendance indicated that they had incorporated each intervention into their project design (with the exception of 'revision of professional roles' in residential aged care). The extent to which these were all explicit interventions, or incidental as the project activities unfolded, was not clear; the evaluation team formulated its views on the evidence provided in the project plans, reports and evaluation findings.

In addition to using evidence based interventions, stakeholder engagement is a central component of a planned approach to implementing change. All projects demonstrated an understanding of this in their project plans and the stakeholder engagement and/or governance processes. The extent to which this impacted on the overall project activities, however, varied according to the nature, context and primary target audience of the projects. As expected, the leadership and change projects were more explicit in incorporating multiple factors as they addressed care staff, management as well as organisational and strategic imperatives. Likewise, the community care projects tended to directly engage clients and staff, but were less focused on organisational or system level stakeholders. While the national roll-out projects included resources for a multi-level implementation at the local service level, their primary activities were staff educational workshops and dissemination of resources.

Of particular concern is the relatively low level of consumer engagement in the design of projects overall. Only two projects explicitly sought consumer input, perhaps not surprisingly given that CC4 was focussed on consumer directed care, and CC6 was conducted by a consumer organisation. The vast majority of projects were led by teams of academics, health care professionals and/or service providers, whose traditional relationship with clients is one of 'doing to' rather than 'doing with'. While the aged care reforms were viewed as a great enabler by a number of project leads, with its focus on person centred and consumer directed care, wellness and enablement, this approach was not evident in the project activities. Consideration needs to be given to the best means of ensuring consumer input underpins all future sector improvement initiatives and they fulfil their role as 'partners' in the development of a sector designed to meet their needs, as indicated in the recently released Aged Care Sector Statement of Principles:



*The Statement of Principles recognises the benefit in consumers, providers, the workforce and the Australian Government collaborating to realise an aged care system that will meet the needs of Australia's ageing population.<sup>71</sup>*

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<sup>71</sup> Aged Care Sector Statement of Principles, *Approach to Partnerships* (Feb 2015) available at [https://www.dss.gov.au/sites/default/files/documents/02\\_2015/aged\\_care\\_sector\\_statement\\_of\\_principles\\_-\\_final\\_feb\\_2015\\_0.pdf](https://www.dss.gov.au/sites/default/files/documents/02_2015/aged_care_sector_statement_of_principles_-_final_feb_2015_0.pdf)

## 10 CONCLUSION AND RECOMMENDATIONS

The significant investment by the Australian Government in recent years to improve evidence based practice has impacted directly on the many clinical and care workers who have participated in the training and workshops provided, as well as their improved access to evidence-based resources. The projects have explicitly sought to address organisational and systemic factors likely to impact on implementation, through development of new resources, tools, processes and aligning innovations with regulatory frameworks and strategic reforms. The extent to which these two aspects are integrated at the local level is ultimately dependant on whether there is organisational commitment to the innovations which is followed through by enabling policies, processes and, importantly, resources.

Importantly, the EBPAC program has also resulted in a better understanding of what works in aged care, and what needs to be in place in order for innovations to succeed. The heterogeneous and dynamic nature of the aged care sector means there is no one simple formula to facilitating change in a consistent and coherent manner. The complex interaction between consumer, workforce, organisational and systemic factors will continue to pose challenges to the provision of evidence-based practice and will need to be explicitly addressed to ensure that the benefits of any future investments are realised. What is clear from the emerging research evidence, and the experience of the EBPAC program however, is that the development of resources and delivery of education alone will not lead to sustainable outcomes.

Each project included a series of recommendations to the Department arising from the lessons learned. The evaluation team does not purport to be experts in the clinical areas addressed in each of the EBPAC projects, and therefore is not in a position to judge the merit or otherwise of these project level recommendations; however, we would strongly recommend that the Department carefully review the project level recommendations in light of the evidence provided in each report, and consider these on an individual basis.

What is clear from the overall program evaluation is the importance of any new initiative to be underpinned by the evidence regarding implementation. There are clear opportunities for government to leverage off the important foundations laid by the three EBPAC rounds and the numerous workforce development activities currently underway. In particular, these investments have built capacity amongst the many project leaders, team members and participants; developed and strengthened intra- and inter-sector partnerships; and, significantly, initiated and/or revived enthusiasm and commitment amongst those directly responsible for the day to day support and care of aged care clients. To ensure that these gains are not lost, and the resources developed are not just added to the already crowded aged care educators' shelves, the evaluation team suggests the following recommendations:

1. A central repository and electronic portal be developed to host and disseminate the resources developed under EBPAC and similar Commonwealth-funded initiatives, and linked with existing websites accessed by the sector, as appropriate. e.g., Dementia Training Studies Centres, Aged Care Quality Agency.

2. Sector development initiatives to be co-ordinated across government and in partnership with stakeholder representatives to ensure the multiple perspectives are appropriately captured, optimise learnings and avoid duplication of effort.
3. Consumer outcomes to be integrated into quality reporting across the sector, and directly linked to funding and licencing agreements.
4. Future sector development initiatives to reflect contemporary evidence-based practice and utilise multi-level interventions.
5. Evaluation should be seen as an integral part of the policy cycle and utilised in assessing whether previous government funding initiatives have achieved their objectives. This approach will facilitate ongoing improvements in the outcomes of future funding initiatives.

## APPENDIX 1 - TARGETED LITERATURE REVIEW

### **Implementing evidence based practice within a community care context: a targeted literature review.**

#### **Objective:**

To identify the factors that are important to assist in the ability of those working in the community care sector to access and implement evidence based practice.

#### **Method:**

Undertake targeted literature review of journal articles published from 2000 to current. Searches included: PubMed, Cochrane Database, EBSCO (Medline, Cinahl, Econlit, Academic Search Complete, Health Source: nursing/academic edition). In addition, a snowball approach was used, reviewing references in key articles, as well as searching websites that are known to contain information on the subject, e.g., Canadian Health Services Research Foundation; Department of Health and Ageing, US Centre for Disease Control and Prevention

#### **Search terms:**

Community care; evidence; best practice; aged; elderly; clinical leadership

#### **Results:**

PubMed: 238 articles; 5 of which were considered relevant: Seers et al (2012); Van't Leven et al (2011); Peel et al (2010); Hunter, DJ (2010); Cherry et al (2009)  
Cochrane: 1st search (no 'leadership'): 322 articles; 2 relevant: Renders et al (2000) and Forsetlund et al (2009); 2nd search (incl. 'leadership'): 15 articles; 2 relevant: Grimshaw et al (2012) & Flodgren et al (2011)  
EBSCO: 64 articles; 3 relevant: DeCicco J (2008); Bryant et al (2006); Perkins et al (2011)

#### **Additional articles identified through snowballing techniques:**

Whitelaw (2010); McCallion and Ferretti (2010); Walsh (2010); Stevens et al (2012)  
Peel et al (2010); Hollander and Prince (2008);

#### **Discussion:**

There was limited information available that specifically targeted the implementation of evidence based practice for clients in receipt of, and services providing, community aged care services. The predominant literature regarding knowledge translation and implementation science tends to be within the acute health, primary care and residential aged care settings.

Of the limited articles and resources found, there were a number of themes emerging that needed to be taken into account in implementing evidence based practice within community care services. These include:

- Numerous services/stakeholders involved in delivering community care, arising from the often complex nature of health and care needs of recipients (DeCiccio 2008; Whitelaw 2010)

- Workforce issues arising from, and required to address, this complexity of service/care/stakeholders (Bryant et al 2006);
- Turf/boundaries between services (Hollander and Prince 2008);
- Cultural differences between service types – e.g., medical model versus psychosocial enablement and personal independence (McCallion and Ferretti 2010; Hollander and Prince).

Consequently, there is greater need for services to work in partnership and collaboratively, both within and across different services and stakeholder groups (Peel et al, Stevens et al). This heightened, therefore, the need for a planned approach to implementing evidence-based interventions in a community context, to enable the following issues to be addressed:

- Building consensus on the evidence base, and the perceived outcomes for clients, amongst the various stakeholders (Whitelaw 2010; McCallion and Ferretti, 2010);
- Identifying organisational readiness for change; (Bryant et al 2006; Peel et al 2010);
- Targeting interventions to select population groups and addressing contextual factors (Hunter 2010);
- Building effective working relationships through planning days, workshops etc. (Peel et al 2010);
- Providing technical assistance of staff (training) to undertake and implement new processes (Perkins 2010);
- Providing sufficient resources and time to support implementation (Peel et al 2010; Hunter 2010; McCallion and Ferretti 2010);
- Development of appropriate communication plans and integrated information systems across different sites and work groups (Hollander and Prince 2008);
- Importance of evaluation and continuous quality improvement culture and systems (Hunter 2010)

Perhaps the most comprehensive approach to implementing evidence-based client-centred care for older people receiving community care services is the framework developed by Hollander and Prince (2008), which was developed for organising health care delivery for people within ongoing care needs and their families. The framework arose from the results of a Canadian project to study systems of care for four populations with ongoing care needs, including the elderly, people with disabilities, persons with chronic mental health conditions and children with special needs. The complex care needs associated with these groups, and the associated stakeholder engagement and contextual factors associated with delivering that care, resonate with those of the population groups being targeted under EBPAC.

They identified the following factors to address the challenges associated with care coordination and implementation of evidence based practice:

- Philosophical and policy prerequisites – that articulate commitments regarding the model of care, appropriate resourcing, analysis and evidence-based decision making.
- Organisational design factors addressing administrative and clinical issues. These include services having a clear articulation of the philosophy of care, which is enacted through streamlined administrative arrangements, single reporting and funding streams, integrated electronic information systems and the use of rewards and incentives for

evidence based management. On the clinical side, the best practice included the capacity to coordinate entry into the system (through consistent screening tools), consistent assessment of need and classification of care; case management and the involvement of clients and families.

- Coordination and boundary spanning linkage mechanisms, across population groups, service administrative systems and, potentially, staff.

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## APPENDIX 2 - PROJECT SUMMARIES

<b>Project title</b>	<b>CL1: Bridging the Leadership Skill Gap</b>
<b>Lead organisation</b>	TAFE Queensland
<b>Consortium partners</b>	TAFE Queensland Brisbane, Strategon, Recovery Station
<b>Participating organisations</b>	Ten aged care facilities participated in the project across QLD, NSW and SA.
<b>Funding</b>	\$687,500 from 1 June 2012 to 29 January 2015
<b>Overview</b>	This project was led by TAFE Qld Brisbane in conjunction with Strategon, a South Australian based business advisory and enterprise development consultancy and Recovery Station, a New South Wales based provider of allied health. Ten aged care facilities participated in the project across the three states. The project involved a competency based framework approach to underpin training and development opportunities for participants to undertake a leadership project in a subject of their choice.
<b>Project delivery</b>	The project developed and provided leadership training to 120 residential community and residential aged care staff, recruited and selected by ten participating RACPs across three states. The implementation framework used to develop the Emerging Leaders training resource comprised a five stage process: <ol style="list-style-type: none"> <li>1. Initial consultations with registered residential aged care providers across three states</li> <li>2. Capability profiling</li> <li>3. Development of the training resource</li> <li>4. Piloting phase comprised of a one-day workshop series and action learning projects</li> <li>5. Finalisation of training resources based on feedback from stakeholders</li> </ol>
<b>Resource development</b>	A learning and development methodology has been developed, including a training resource that RACPs can use to skill 'emerging leaders' across the staff pool in the leadership skills required to achieve strong outcomes for clients.
<b>Main intended outcomes</b>	The aim of the Emerging Leaders Program is to improve leadership capacity within the aged care and community sectors through the provision of a leadership training resource.
<b>Project evaluation</b>	Changes many RACPs observed as a result of participation in the program included: <ul style="list-style-type: none"> <li>▪ Improved care processes for clients with a greater focus on the client and the provision of individualised care</li> <li>▪ The empowerment of staff to identify areas for improvement and help foster change for better client care outcomes</li> <li>▪ Increased confidence amongst staff in the care process addressed in the project due to sharing of information and ability of project staff in seeking evidence to help guide practice</li> <li>▪ An increased understanding of the roles between all staff with greater communication and collaboration across disciplines</li> <li>▪ Greater work efficiencies with improved care and communication processes</li> </ul>

<b>Project title</b>	<b>CL2: Clinical Mentoring: from Evidence-Base to Outcomes for Older People</b>
<b>Lead organisation</b>	Resthaven Inc.
<b>Consortium partners</b>	Resthaven Inc., Wesley Mission Brisbane, Alwyndor and Fullarton Lutheran Homes.
<b>Participating organisations</b>	Six facilities across three states SA, NSW and Qld
<b>Funding</b>	\$1,320,000 from 5 June 2012 to 29 January 2015

<b>Overview</b>	<p>This project built on a range of research and development initiatives undertaken by Resthaven in recent years, and its existing working relationship with Flinders University. The two organisations were successful in receiving funding for a Training and Research Aged Care Services (TRACS) initiative at the same time as the EBPAC project funding. The project manager appointed by Resthaven was responsible for both of these projects.</p> <p>The project involved supporting and developing clinical mentors in six facilities across three states (SA, NSW and Qld), each of which had a focus on a specific clinical/workforce issue pertinent to that organisation.</p>
<b>Project delivery</b>	<p>Funding was provided for clinical mentors (2 days/week) and champions (1 day/week) in each participating facility. Clinical mentors were selected from each site and participated in workshops with clinical mentor experts; upon returning to their home facility/service, mentors worked with local champions to create a team to support them in their area of clinical focus. This small team received ongoing support from external mentors, both face to face and over the phone, as they sought to identify the evidence, practices and processes for change.</p> <p>The primary focus of the clinical mentor was to provide leadership in change management; the clinical area of practice change was essentially secondary to this primary objective. Mentors were chosen who were identified as 'influencers' within an organisational context, had research and project management skills, and a capacity to influence staff working with them, as well as management.</p>
<b>Resource development</b>	Aged Care Clinical Mentor Model of Change: Six Steps to Better Practice. A guide for Implementing Clinical Change through Workforce Development
<b>Main intended outcomes</b>	Clarification of mentor attributes, and development of a model of change that could be used across care settings and the sector more widely.
<b>Project evaluation</b>	The project predominantly used pre- and post- implementation measures, around staff satisfaction/skills/retention, as well as clinical competencies. By linking the focus of projects to operational imperatives (i.e., clinical indicators, quality improvement processes) the project outcome was able to demonstrate real change in terms of client and workforce outcomes.

<b>Project title</b>	<b>CC1: Better practice for older people living with or at risk of chronic wounds in the community</b>
<b>Lead organisation</b>	Royal District Nursing Services (RDNS)
<b>Consortium partners</b>	Victoria: Royal District Nursing Service, Department of Health, Goulburn Valley Health, Bendigo Health, Barwon Health, Ballarat District Nursing and Healthcare and Austin Health Wound Clinic Western Australia: Silver Chain Nursing Association
<b>Participating organisations</b>	Mix of health and aged care services in Vic and WA – as per above
<b>Funding</b>	\$800,800 from 1 July 2012 to 1 December 2014
<b>Overview</b>	This project comprised three sub-projects, all of which built on existing processes within RDNS and broadened to different audiences and modes of delivery: the Leg Ulcer Prevention Program and the Skin Awareness Program, both of which targeted older people living in their own homes, and a clinical leadership model in the area of wound care.
<b>Project delivery</b>	<p>The Leg Ulcer Prevention Program (LUPP) implemented a clinical practice guideline based e-learning package which was delivered by nurses to educate people with venous leg ulcers about their wounds. The aim was to encourage clients to increase adherence to evidence-based treatments, and thereby improve health outcomes.</p> <p>The Skin Awareness Package (SAP) sought to prevent skin injury through the development and implementation of a clinical practice guideline based e-learning package on skin health; this was also delivered by health workers to educate older people on skin health.</p> <p>The clinical leadership group model was expected to underpin the above training processes and evidence based practice in wound care management.</p>



<b>Resource development</b>	<p>The LUPP Resource Kit included a LUPP information sheet, LUPP protocol, LUPP protocol flow chart, data collection tools, LUPP clinician guideline, information for healthcare providers and LUPP study training guide. A DVD and supporting LUPP booklet was also made available as an e-learning device. Miscellaneous skin care samples, bandages and a water bottle were also supplied as part of the kit.</p> <p>The SAP Resource Kit included a SAP information sheet, data collection tools, a skin assessment tool, the SAP study training guide and additional information for healthcare providers. A DVD and supporting SAP booklet was also made available as an e-learning device. Miscellaneous skin care samples, bandages and a first aid pack were also supplied as part of the kit.</p>
<b>Main intended outcomes</b>	To deliver e-learning client education packages for care recipients to promote and support the uptake of better wound management practice and to assist the aged care and health workforce to enhance their knowledge and skills around wound management and care.
<b>Project evaluation</b>	<p>Two hundred nurses delivered LUPP to 229 people with venous leg ulcers. In people with venous leg ulcers, LUPP led to an increase in knowledge of venous leg ulcers, and the adoption of some of the recommended behaviour changes promoted in LUPP. The nursing staff delivering LUPP felt that LUPP taught them additional information about the care of people with venous leg ulcers, and also systematised the care they already delivered.</p> <p>Ninety-five health workers were trained to deliver SAP to 100 older community members, with 22 health workers facilitating SAP delivery. The community members who engaged with SAP increased their knowledge of skin health and adopted some of the behaviours recommended by SAP. The health workers who had SAP training also increased their knowledge of skin health which led them to increase their roles and responsibilities, including applying a preventative approach to prevent the escalation of minor skin issues to more serious problems. This increase in health worker roles and responsibilities led to an increase in respect by nurses of the role health workers can play in preventing serious skin issues, and ultimately led to a more collaborative approach in care delivery by these care providers.</p>

<b>Project title</b>	<b>CC2: The Lifestyle Engagement and Activity Program (LEAP) for Life Project in Community Care</b>
<b>Lead organisation</b>	The University of NSW
<b>Consortium partners</b>	BaptistCare – South West Sydney, BaptistCare – Central Coast, Multicultural Community Care Service, Australian Nursing Home Foundation, The Whiddon Group - Glenfield
<b>Participating organisations</b>	As per consortia arrangements
<b>Funding</b>	\$881,540 from 1 June 2012 to 1 December 2014
<b>Overview</b>	Home care programs have traditionally focussed on catering for the physical and domestic needs of their client, with less focus on social and recreational needs. The LEAP project has developed training materials for care workers to deliver an individualised package of care that combines the best elements of activity programs in aged care, such as physical activities, Montessori activities, music, reminiscence and humour. It takes the evidence base for person-centred activities in residential care and applies them to community care.
<b>Project delivery</b>	<p>There were three stages in implementing LEAP:</p> <ul style="list-style-type: none"> <li>▪ Engaging management and staff to support the program: Engagement was supported by the role of the project officer who provided dedicated support to each of the five aged care community services. Sites were given the flexibility to implement LEAP in a manner which suited their model of care.</li> <li>▪ Employing a LEAP Champion one day per week to drive practice change: LEAP Champions were trained at each site to drive the sustained behavioural change of care workers and case managers. The Champions also accompanied each care worker on a buddy visit to a client in order to support care workers in practising client engagement techniques.</li> <li>▪ Staff training: LEAP Champions received one, five hour training session focussing on clarifying the role of the Champion, change management, improving interpersonal skills focussing on</li> </ul>

	<p>person persuasion and brainstorming potential barriers of implementation. Case Managers received one, three hour training session introducing them to the aims of the program and how to set SMART goals with clients. Care workers participated in four, two to three hour sessions held every three months.</p>
<b>Resource development</b>	<p>Numerous resources were developed to support the implementation of LEAP. These included:</p> <ul style="list-style-type: none"> <li>▪ 1 x Case Manager Training Facilitator Manual (+ handout booklet)</li> <li>▪ 1 x LEAP Champion Training Facilitator Manual (+ handout booklet)</li> <li>▪ 4 x Care worker Training Facilitator Manuals (+ a handout booklet for session 2).</li> <li>▪ 1 X 'Guide for the Trainer' booklet including program overview and a recommended reading list.</li> </ul> <p>Five short videos about LEAP were also produced as training and promotional resources as follows:</p> <ul style="list-style-type: none"> <li>▪ A 12-minute summary of LEAP</li> <li>▪ A 3-minute overview of LEAP</li> <li>▪ A 3-minute video of late-stage dementia</li> <li>▪ A 3-minute video of early-stage dementia</li> <li>▪ A 3-minute video about 'Mr Ton', a Vietnamese gentleman who began to write poetry on his computer because he felt lonely.</li> </ul>
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ To develop training materials for the Lifestyle Engagement and Activity Program (LEAP) for Life project for community care</li> <li>▪ To implement LEAP for Life in community car</li> <li>▪ To evaluate the effectiveness of the implementation and outcomes of LEAP for Life in community care</li> </ul> <p>These outcomes were tested with a diverse range of home care providers; in terms of size, location and cultural background.</p>
<b>Project evaluation</b>	<p>The evaluation featured multiple observations at four occasions both pre, during and post intervention. Evaluation subjects included case managers, LEAP Champions, care workers, clients and family/carer. Methods included semi-structured interviews, questionnaires and the analysis of care worker diary records. Specific assessment tools were also used to measure client outcomes such as client agitation, loneliness depression apathy and satisfaction with care.</p> <p>A total of 189 clients, 152 care workers and 28 case managers participated in the evaluation. Twelve months after the program commenced 87% of clients had a social/recreational goal and 76% had an engagement strategy in their care plans. Clients showed a significant increase in researcher-rated engagement, and a significant decrease in researcher-rated apathy, dysphoria and agitation. Both case managers and case workers reported a significant increase in their confidence to socially and recreationally engage clients. Case managers also reported a significant increase work satisfaction.</p>

<b>Project title</b>	<b>CC3: Home-based Preferred Music Listening Program</b>
<b>Lead organisation</b>	Chinese Community Social Services Centre Inc. (CCSSCI)
<b>Consortium partners</b>	National Ageing Research Institute, Alzheimer's Australia Victoria, CCSSCI HCPP and a Registered Music Therapist.
<b>Participating organisations</b>	Chinese Community Social Services Centre Inc. (CCSSCI)
<b>Funding</b>	\$297,000 from June 2012 to 1 December 2014
<b>Overview</b>	This project aims to improve the mood status of clients of the CCSSCI through a 'music intervention' implemented whilst personal and home care services are being provided by Direct

	Care Workers (DCW) in the client's home. The client's favourite music is played for about 30 minutes and a smiling face mood scale tool is used to measure whether the intervention had a positive impact on the client's mood.
<b>Project delivery</b>	Clients who consented to participate in the program completed a music survey to establish their individual musical profile and their preferred music. At the same time, home care workers and their managers participated in workshops focussing on music therapy and understanding ageing and dementia. Individual music CDs were then produced for each client based on their feedback to the music survey and their interactions with a qualified music therapist. Home care workers then conducted the music intervention during their regular home care service. Clients and families were also encouraged to perform the preferred music activities daily with the guidance of the 'Step by Step' manual provided. All stakeholders were encouraged to take an interactive approach to music listening by singing together, moving with the music or talking about the memories that the music evoked.
<b>Resource development</b>	Each client who participated in the program and their family/carers received a personalised music CD and a CD player. They also received a 'Step by Step' manual to facilitate their preferred music listening activities as well as a songbook with contains the lyrics to the selected songs.
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ To improve elderly clients' mood status</li> <li>▪ To reduce family carers' stress</li> <li>▪ To increase Home Care Workers' job satisfaction</li> </ul>
<b>Project evaluation</b>	<p>A 'Faces Scale' was used to assess the participants' mood pre and post the music listening activities. These data were collected and collated by the home care worker for a five month period. Focus group and telephone interviews were held with clients, family carers and Home Care Workers. Case studies were undertaken to profile individual HCPP clients, Home Care Workers and Case Managers to share their experiences about the music intervention.</p> <p>The Faces Scale highlighted that 83.3% of participants experienced improvements in their mood after the home-based music listening activities. Focus groups and interviews with clients and their carers/families demonstrated that music listening helped them to be distracted from negative feelings and pains and helped them to relax. Families and carers experienced reduced stress in their caring role. Home Care Workers experienced an improved working relationship and an increased level of trust with their clients. They also reported that their job satisfaction increased as a result of participating in the program.</p>

<b>Project title</b>	<b>CC4: CHOICES</b>
<b>Lead organisation</b>	Uniting Care LifeAssist and Deakin University
<b>Consortium partners</b>	Victoria: Uniting Care LifeAssist, Deakin University, Fronditha Care Inc. (CALD specific), Uniting Care Gippsland NSW: Uniting Care Ageing NSW/ACT
<b>Participating organisations</b>	As per consortia arrangements
<b>Funding</b>	\$550,000 from 29 May 2012 to 1 December 2014
<b>Overview</b>	This project is based on the People at Centre Stage project (PACS), a previously funded Australian Research Council project conducted by Uniting Care Community Options. The PACS model was developed with direct input from both service users and service providers and was designed to assist participants maintain/build their health, strengthen their capabilities and attain their preferred level of independence. It was specifically designed for people with complex care needs and places great emphasis on capacity building. The CHOICES model specifically targets Cultural issues specific to the 3 distinctive needs groups (ATSI, CALD and Regional).
<b>Project delivery</b>	The key stages to the delivery of the CHOICES model involved the following steps:

	<ul style="list-style-type: none"> <li>▪ Developing and making available tools and an implementation guide geared to assist implementation of the model</li> <li>▪ Delivering training workshops, online training modules, refresher courses and face to face mentoring,</li> <li>▪ Developing and making available practice tools (including needs assessment tools) for case managers,</li> <li>▪ Integrating client feedback on service gaps into a distinctive needs overlay outlining issues and potential solutions to address these gaps</li> <li>▪ Developing and disseminated practice guidelines on how to implement the overlays to address the specific needs of the communities in question</li> </ul>
<b>Resource development</b>	<p>The project produced a number of resources in support of the CHOICES model:</p> <ul style="list-style-type: none"> <li>▪ An online training package</li> <li>▪ Training workshop materials</li> <li>▪ A suite of practice tools and an Implementation Guide</li> <li>▪ A CM readiness questionnaire</li> <li>▪ A CHOICES information booklet</li> <li>▪ A Community Connectors Program</li> </ul> <p>Many of these resources are available on the project website: <a href="http://www.choicesinagedcare.com.au/">http://www.choicesinagedcare.com.au/</a></p>
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ To develop a CDC model responsive to the needs of people living in regional/rural, Greek, and indigenous communities.</li> <li>▪ To develop training packages for case managers and care coordinators supporting people in regional/rural, Greek, and Aboriginal communities.</li> <li>▪ To evaluate the effectiveness of the CDC model.</li> </ul>
<b>Project evaluation</b>	<p>The quantitative data suggests that the CHOICES model had a statistically significant effect on the perceived quality of case management. Overall, clients felt more respected, informed, and appreciated the new financial arrangements.</p> <p>Aboriginal Elders and participants in rural/regional communities commented positively on their ability to spend their package funds more flexibly and appeared to be more aware and empowered to receive care responses that resonated better with their needs. However, only half of the sample experienced key aspects of the CHOICES model and as a result the sample size was not statistically significant.</p> <p>The findings do demonstrate that many frailer old people will require considerable support in order to take advantage of CDC opportunities.</p>

<b>Project title</b>	<b>CC5: Building Better Oral Health Communities</b>
<b>Lead organisation</b>	SA Dental Service
<b>Consortium partners</b>	<p><b>Public Dental Providers:</b> SA Dental Service, SA – lead organisation Hunter New England Oral Health, NSW</p> <p><b>Home Care Providers:</b> Helping Hand Aged Care Inc. SA – Country Community Care Program Helping Hand Aged Care Inc. SA – Metro Community Services Aboriginal Elders &amp; Community Care Services Inc. SA – Aboriginal Home Care BaptistCare NSW &amp; ACT – Hunter Care</p>

<b>Participating organisations</b>	As per consortia arrangements
<b>Funding</b>	\$1,426,700 from 5 June 2012 to 29 January 2015
<b>Overview</b>	This project builds on the work previously undertaken in Round 1 of EBPRAC, which targeted residential aged care, extending the skills development and capacity building to community dwelling aged care clients and service providers.
<b>Project delivery</b>	<p>The development of a home care model of oral health care builds on the seminal research of Dr Jane Chalmers and the findings of the Better Oral Health in Residential Care Project. Key to this was the integration of four key oral health processes (oral health assessment, evidence-based oral health care planning, support with daily oral care and referral to a dental professional) into routine care. A suite of oral health education and training resources were developed to support the implementation of these processes.</p> <p>The Better Oral Health in Home Care Model was designed to promote a home care team approach aimed at maintaining a client's oral health. Its aim was to encourage GPs, nurses, care coordinators, home care workers, dental professionals, clients and their families to share the responsibility for implementing one or more of the four key oral health processes.</p>
<b>Resource development</b>	<p>The project developed a variety of resources in different mediums as follows:</p> <p>Better Oral Health in Home Care Resource; Better Oral Health in Home Care Facilitator Guide; Audio Visual Resources:</p> <ul style="list-style-type: none"> <li>▪ Care workers – oral health heroes (14 minutes)</li> <li>▪ Dementia and oral care (9 minutes)</li> <li>▪ It starts with the mouth (9 minutes)</li> <li>▪ Care of natural teeth (10 minutes)</li> <li>▪ Care of dentures (5 minutes).</li> <li>▪ Auntie Elsie (5 min) indigenous specific;</li> </ul> <p>Templates for dental referral and dental care recommendations; dental referral pathway; dental visit checklist; and an oral health changes reporting guide; and</p> <p>Client resources, including bathroom prompts in the care of natural teeth and care of dentures; and Oral health self-care booklets for indigenous and non-indigenous communities.</p>
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ To facilitate a sustainable multidisciplinary approach to oral health care</li> <li>▪ To adapt the Better Oral Health in Residential Care resource portfolios to suit the home care context</li> <li>▪ To improve access by the home care workforce to evidence-based oral health information</li> <li>▪ To provide opportunities for oral health education and training to the home care workforce</li> <li>▪ To improve oral health care for recipients of home care services</li> <li>▪ To identify dental pathways for timely dental care for frail older people</li> <li>▪ To increasing community awareness of the importance of good oral health through age-friendly resources for older people, their families and informal carers</li> </ul>
<b>Project evaluation</b>	The project involved a series of pre- and post-implementation measures. The Better Oral Health in Home Care Model demonstrated positive improvements in home care clients' oral health related quality of life and wellbeing, as well as improvements in care staff knowledge and skills.

<b>Project title</b>	<b>CC6: Valuing People: Person-Centred Dementia Support Project</b>
<b>Lead organisation</b>	Alzheimer's Association Vic
<b>Consortium partners</b>	ACH Group, Baptcare, Brotherhood of St Laurence, Royal District Nursing Service, Swan Hill Rural City Council and Southern Cross Care.

<b>Participating organisations</b>	As per consortia arrangements
<b>Funding</b>	\$574,200 from 4 June 2012 to 1 December 2014
<b>Overview</b>	This project was undertaken by Alzheimer's Australia Victoria (AA Vic) building on a project that was funded through Alzheimer's Australia's National Quality Dementia Care Initiative. The additional funding under EBPAC enabled additional pilot testing of the tools and targeted resource development. It aimed to provide a tool to enable consumers as well as providers assess the capacity of a community care service to deliver person-centred care for people with dementia.
<b>Project delivery</b>	Following an initial literature review and consultation with key stakeholders including consumers and academics, a draft 'Organisational Self-Assessment Tool (OSAT)' was piloted in a range of aged care community care services. The interim evaluation indicated the need for significant refinements. The re-worked tools were more succinct and accessible, and re-piloted with a further group of services, including one for-profit agency. It was recognised that delivering person-centred care was appropriate for all clients, not just those with dementia; in addition, it shifted its focus to include internal staff processes in recognition of the fact that if staff weren't feeling valued, they were unlikely to value and respect their clients.
<b>Resource development</b>	'Valuing People - An organisational resource enabling a person-centred approach', a document which describes person centred principles, an approach to self-assessment of organisational person-centredness, a change management strategy, and five Organisational Self-Assessment Tools (OSATs) to be used in the self-assessment: an OSAT for consumers, carers, direct care workers, non-direct care workers and organisational leaders; A Valuing People website, which, following registration, supports web-based data entry and analysis for the organisational self-assessment.
<b>Main intended outcomes</b>	The project resulted in the development of a resource that supports organisational change to focus on relationships, rather than processes. National workshops were conducted to assist organisations utilise the tool, including capacity building within the Alzheimer's Australia network to champion, distribute and, where needed, facilitate the resource.
<b>Project evaluation</b>	An independent evaluation was conducted, both formative and summative aspects. The formative evaluation was to provide quantitative and qualitative data to inform the development of the person-centred dementia support resources, while summative evaluation was to assess the impact of the resources on the quality of dementia care, particularly from the consumer's perspective. As no individual provider has used the Resources to develop and implement an action plan, it is premature to evaluate whether the Resources have led to an increased use of evidence in everyday practice.

<b>Project title</b>	<b>RC1: National Rollout of the Palliative Approach Toolkit for Residential Aged Care Facilities</b>
<b>Lead organisation</b>	Brisbane South Palliative Care Collaborative
<b>Consortium partners</b>	The Australian and New Zealand Society of Palliative Medicine Leading Age Services Australia The Royal Australian College of General Practitioners The University of Queensland/Blue Care Research and Practice Development Centre
<b>Participating organisations</b>	1,540 facilities represented at the workshops
<b>Funding</b>	\$2,000,000 from 6 September 2012 to 30 April 2015
<b>Overview</b>	This project was previously funded in Round 2 of the EPBRAC program. Under Round 2 the Comprehensive Evidence-Based Palliative Approach in Residential Aged Care project was able to demonstrate successful changes in clinical practice which resulted in improvements in resident care, staff knowledge and family satisfaction. This current project tests the rollout of the model on

	a national basis.
<b>Project delivery</b>	<p>The rollout of the project was divided into five key stages:</p> <ul style="list-style-type: none"> <li>▪ Stage 1: Governance and structures - staff recruitment, establishment of steering committees, clinical reference groups and project working group.</li> <li>▪ Stage 2: Communication - communication strategy developed that promoted the use of the PA Toolkit and the workshops to key stakeholders</li> <li>▪ Stage 3: Resource development - six new resources developed and distributed along with the existing toolkit</li> <li>▪ Stage 4: Training – the delivery of national workshops</li> <li>▪ Stage 5: Continuous quality improvement - promoted the need for continuous quality improvement through two audit tools related to the RACF accreditation processes</li> </ul>
<b>Resource development</b>	<p>The toolkit was developed in Round 2 of the EPBRAC program. However, new management, clinical and educational resources were added to the existing PA Toolkit. These resources were developed to guide and support RACFs to implement a comprehensive, evidence-based, person-centred and sustainable approach to palliative care for appropriate residents. The resources were developed with input from members of the Steering Committee and Clinical Education Reference Group after extensive input from the aged care sector.</p>
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ To deliver a minimum of 30 workshops to promote the use of the PA Toolkit, on a state-by-state basis, to RACF managers, educators, and staff, and external stakeholders such as GPs.</li> <li>▪ Support the sustainable use of the PA Toolkit by developing infrastructure resources including train-the-trainer and a management support manual for inclusion in the PA Toolkit.</li> <li>▪ Further embed evidence-based practice in RACFs by developing new resources for inclusion in the PA Toolkit that support the translation of evidence-based palliative care guidelines into policy and practice.</li> <li>▪ Encourage sustainable links between RACF generalist providers and SPCS by encouraging the establishment of RACF Link Nurse positions networked to SPCS providers.</li> <li>▪ Develop a multimedia marketing strategy for aged care stakeholders to promote the use of the PA Toolkit.</li> <li>▪ 1,540 Promote continuous quality improvement in RACFs using an evaluation framework that allows staff to review resident end of life outcomes based on the use of the PA Toolkit.</li> </ul>
<b>Project evaluation</b>	<p>The team delivered a total of 42 workshops to promote the use of the PA Toolkit to RACF management, educators, staff and external providers. In addition, 19 one day train-the-trainer workshops were held in Victoria for the VPCC. These were attended by approximately 2,250 staff from 1,276 RACFs.</p> <p>The PA Toolkits have been distributed nationally: 2,720 to approved RACFs, 70 to other RACFs (i.e. private, multi-purpose sites and new facilities), and 210 to organisations to support RACFs to implement the palliative approach including the VPCC, aged care trainers, and SPCS.</p> <p>Participant feedback about training indicated that a significant majority found the workshops to be directly relevant to their day-to-day practice and were of a high quality. Evaluation data also suggested that the workshop content had increased participants' knowledge about, and confidence in, implementing an evidence-based palliative approach to care.</p> <p>The project facilitated the establishment of sustainable links between RACF generalist providers and SPCS through the development of the PA Toolkit resource Workplace Implementation Guide: Support for Managers, Link Nurses and Palliative Approach Working Parties.</p> <p>The project promoted continuous quality improvement by promoting the use of two audit tools to support the implementation of the PA Toolkit: the After Death Audit Tool and the Organisational Policies and Structures Audit Tool. These tools allow staff to review resident end of life outcomes based on the use of the PA Toolkit.</p>



<b>Project title</b>	<b>RC2: Improving Wound Management for Residents in Residential Aged Care Facilities: National Dissemination and Implementation of the Evidence Based Champions for Skin Integrity Program</b>
<b>Lead organisation</b>	School of Nursing, Queensland University of Technology
<b>Consortium partners</b>	N/A
<b>Participating organisations</b>	N/A
<b>Funding</b>	\$725,076 from 7 September 2012 to 30 June 2014
<b>Overview</b>	This project was previously funded in Round 2 of the EPBRAC program where the Champions for Skin Integrity Program was successful in increasing implementation of evidence based wound management and decreasing the prevalence and severity of wounds in residents of RACFs. This project had an overall aim of further promoting the skin integrity of the residents of Residential Aged Care Facilities throughout Australia by utilising the resources developed and knowledge gained in the EBPRAC-CSI Stage 1 project to promote the uptake of the CSI model of evidence based wound management. This was facilitated by conducting a series of Promoting Healthy Skin 'Train the Trainer' workshops in the capital cities and major regional centres throughout Australia.
<b>Project delivery</b>	The original resources developed in the EBPRAC-CSI Stage 1 project were submitted for a secondary review by academics with expertise in the area. Also, a full review of the latest evidence was carried out to ensure that the resources developed as part of the new project reflected the latest evidence. The finalised resources were refurbished and redesigned and distributed to all Residential Aged Care Facilities throughout Australia. Learning material were then developed to support a one day intensive workshop focussed on providing attendees with the knowledge and skills to implement the CSI model of wound management. These 'train the trainer' workshops were then rolled out in the capital cities and major regional centres throughout Australia.
<b>Resource development</b>	As mentioned above, a full evidence review was carried out on the material produced during the EBPRAC-CSI Stage 1 project and the relevant evidence based changes were made to the documentation. At the same time participants in the EBPRAC-CSI Stage 1 project were interviewed for advice on how to improve the resource material. Following this the documentation, included in the kit, was sent to independent experts for peer review. When this process was finalised, a learning designer and QUT's Visual Communications Services were engaged to completely refine and update the design of the resources. The kit includes a wealth of resources including evidence base guideline summaries, brochures for health professionals, clients, families and carers, flow charts and tip sheets.
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ To update, refine, promote and distribute the Champions for Skin Integrity Resource Kit, more commonly known as a CSI Resource Kit</li> <li>▪ To facilitate and deliver intensive one day Promoting Healthy Skin 'Train the Trainer' workshops in all capital cities and major regional towns across Australia</li> </ul>
<b>Project evaluation</b>	The CSI Resource Kits were so popular a second print run was necessitated to meet demand. In total, 6,000 kits were distributed. Thirty seven workshops were delivered to 1286 participants who represented 835 facilities. Feedback from workshop participants was positive and pre/post surveys of participants found significantly improved confidence in managing common wound types in older adults, finding and applying evidence in their practice, and implementing change in their workplace. Longer term evidence of uptake of the CSI model in the workplace was demonstrated by action plans and reports detailing progress on implementation projects that were initiated at a CSI Workshop. Resident outcomes from these projects included improved skin integrity, reduced prevalence of wounds, shorter time to healing, increased implementation of EB prevention strategies, improved resident comfort and education and involvement of residents and family in their care. Staff outcomes included increased education provided, improved knowledge, and implementation of protocols and resources which lessened workload.



<b>Project title</b>	<b>RC3: TORCCh (Towards Organisational Culture Change): a process &amp; toolkit for sustainable culture change in residential aged care</b>
<b>Lead organisation</b>	University of Western Australia, Curtin University & RSL Care
<b>Consortium partners</b>	<p>Western Australia: The Bethanie Group - Bethanie Geneff, St Ives Group – St Ives Murdoch and St Ives Melville, Masonic Care WA - Howard Solomon Residential Estate</p> <p>Queensland: RSL Care - Tantula Rise Retirement Community (Alexandra Headlands), Centaur Memorial Retirement Community (Caloundra), Moreton Shores Retirement Community (Thornlands) and Milford Grange Retirement Community (Ipswich)</p>
<b>Participating organisations</b>	As per consortia arrangements
<b>Funding</b>	\$453,849 from 4 September 2012 to 29 August 2014
<b>Overview</b>	<p>This study aimed to develop, implement and evaluate a toolkit and training resources to support sustainable culture change in residential aged care facilities in Western Australia and Queensland.</p> <p>As one of the projects funded under the ACSIHAG Program, a key element of this project is to establish the requirements for sustainability of an organisational culture change intervention both within the participating aged care services but also more widely throughout the aged care sector.</p>
<b>Project delivery</b>	<p>The TORCCh model follows a systematic change process which is facilitated by research staff working with 'champions' at the facility level. This process follows an Action Research approach that follows the QPAR cycle (Question, Plan, Act and Reflect). The toolkit has a strong focus on staff development and recognises the importance of leadership, teamwork and communication. The TORCCh process itself aims to help multidisciplinary teams to implement change in a workplace by going through four stages: Getting ready, getting started, getting active and getting success. Each stage is supported by tools or templates which the team can work through to plan, implement and evaluate their change.</p>
<b>Resource development</b>	<p>Several resources were produced to support the culture change toolkit:</p> <ul style="list-style-type: none"> <li>▪ The Workteam Members' Flipchart: for use by teams making a change in residential aged care facilities. The Flipchart is a step by step guide to help a workteam make a change that they think is necessary.</li> <li>▪ Managers and Workteam Leaders Flipchart: to assist leaders to educate, support and guide teams making a change in residential aged care facilities. It is focused on introductory level information so that a multidisciplinary team can make a change in the workplace.</li> <li>▪ Additional resources and tools that may be of interest can be found at: <a href="http://www.wacha.org.au/resources.html#torch">http://www.wacha.org.au/resources.html#torch</a></li> </ul>
<b>Main intended outcomes</b>	<ul style="list-style-type: none"> <li>▪ Develop, implement and evaluate an organisational culture change toolkit and training resource;</li> <li>▪ Determine the effectiveness of the organisational culture change toolkit and training resource in relation to resident benefits, work culture, leadership and communication;</li> <li>▪ Establish the requirements for sustainability of an organisational culture change intervention within the project aged care services; and</li> <li>▪ Promote a more widespread implementation of the toolkit and training resources throughout the industry.</li> </ul>
<b>Project evaluation</b>	<p>The evaluation was informed by both qualitative and quantitative data. Surveys and interviews were used to assess participants' personal views and experiences of implementing the TORCCh toolkit. Several validated tools were also used such as the Shortell Organisation and Management Survey to measure aspects of team work and collaboration and the Healthcare team Vitality instrument to measure engagement, empowerment and team communication.</p>

	<p>The evaluation highlighted that the TOrCCh protocol was perceived positively by participants, the process of engaging and working with colleagues on common issues or concerns, with a common goal to achieve, was perceived to be both enjoyable and productive. The TOrCCh project proved to be successful in enabling staff to develop skills and knowledge concerning the implementation and evaluation of a change in the workplace.</p>
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## APPENDIX 3 - NATIONAL ROLL-OUT PROJECTS: STAKEHOLDER INTERVIEW REPORT

### 1 Methodology

At least three months after attendance at a workshop, participants were contacted via telephone to participate in an interview about the implementation of the initiatives relating to the two national roll-out projects. A sampling framework was developed (see section 5.1.1 in progress report four) to ensure that a representative sample of services was selected by stratifying for jurisdiction, geographic location and size. Telephone interviews were carried out as follows:

- Champions for Skin Integrity (CSI): a total of 40 interviews were completed between 16 October 2014 and 13 January 2015
- Palliative Approach Toolkit: A total of 31 interviews were completed during 7 January 2015 and 21 January 2015.

### 2 Summary of results

Post workshop implementation results demonstrated that over half of participants indicated that their facility was implementing the initiative. The level of implementation of the toolkits ranged from partial to full implementation and the majority of participants felt the initiatives had been implemented as planned. The majority of participants were also positive about the toolkits.

Participants felt that the use of evidence-based practice, staff skills and knowledge and clinical leadership had improved as a result of the initiatives. Participants also felt the initiatives were sustainable although not necessarily at the same level of implementation.

Barriers to implementation appeared to relate to staffing: fewer staff trained, staff turnover (loss of knowledge), competing priorities and organisational factors. Facilitators of implementation appeared to be the presence of trained and committed staff, more staff trained, supportive management/organisational style.

Participants generally thought the aged care sector was receptive to evidence based practice but also saw needs for both wound management and palliative care in the aged care sector.

### 3 Champions for Skin Integrity (CSI): Telephone Interview Results

A total of 40 interviews were conducted with representatives from aged care facilities who sent staff to CSI toolkit training. The final sample of interviewees included participants from five states, NSW, Queensland, SA, Victoria and WA. Attempts were made to recruit participants from Tasmania and Northern Territory, however, numbers of training attendees in these states/territories were small and participation in the interview was voluntary. No RACFs were willing to participate in an interview in these states/territories. Table 34 below provides an outline of numbers of interviewees from each state. The sample contained

slightly more Rural/Regional RACFs than Metropolitan RACFs. The total number of small and large facilities was the same for all states combined.

**Table 34** *Participants by state, location and size of RACF*

State	number	Rural/Regional	Metropolitan	Large	Small
NSW	7	4	3	3	4
Queensland	7	5	2	3	4
SA	10	4	6	4	6
Victoria	11	6	5	7	4
WA	5	3	2	3	2
<b>Total</b>	<b>40</b>	<b>22</b>	<b>18</b>	<b>20</b>	<b>20</b>

Participants were asked at what level of implementation their facility was at. The majority of facilities (57.5%) had commenced implementation or had fully implemented the toolkit.

Twenty percent of RACFs were planning to implement the CSI toolkit and 20% had no plans to implement the toolkit.

**Table 35** *Implementation by state*

	NSW	Qld	SA	Vic	WA	Total
No plans to implement	2	2		3	1	8
Planning to implement		1	1	6		8
Commenced	5	3	4	2	4	18
Fully implemented		1	4			5
(blank)			1			
<b>Total</b>	<b>7</b>	<b>7</b>	<b>10</b>	<b>11</b>	<b>5</b>	<b>40</b>

### 3.1 Facilities with no plans to implement the toolkit

Interviewees who indicated that their facility had no plans to implement the CSI toolkit were asked a further four questions.

### **What is your understanding of the initiative and the purpose of the project?**

Only four of those who had no plans to implement provided a response to this question. Two interviewees were not sure about the initiative and its purpose, one stating that they had not been spoken to about it. Those that did know about the initiative thought the purpose of the project was:

*To build capacity and awareness of best practice skin care amongst staff, especially less skilled staff and to help implement a program of evidence based skincare in the RACF.*

### **Why do you not intend to implement the CSI toolkit within your facility?**

All of the interviewees in this group answered this question. One interviewee indicated that they had no knowledge of the toolkit. Three interviewees stated that the staff who had attended the training had moved on and implementation was not pursued. Of these, one interviewee did not know whether or not they had the toolkit at the facility. The other noted that:

*We get our wound management guidance from the 'Better Health' Channel.*

Another participant felt they were too new to their organisation to be able to implement change. Two participants felt that they did not need the toolkit as they already had good resources in place such as a good system of wound management and policies and procedures, including training, access to allied health care workers, doctors and specialists from a nearby public hospital.

One participant did provide an outline as to why they eventually did not implement the toolkit:

*After the training the facility I work in changed over to a new computerised patient management system. This proved a challenging process as many of the aged care workers here had not used a computer before. We also didn't realise how big the Tool kit was and I felt that it would be a lot of work to implement. I had thought about using it in 2015 but we are now in construction mode at our facility and I simply have no time. We are a very busy smaller facility and time is precious.*

### **What do you see as the main barriers to implementation within your facility?**

All but one participant from this group answered this question. Of these two participants were not sure what the main barriers were. Time and staff changes were noted as barriers to implementation. One participant felt that a 'whole of government' approach to change was needed.

The importance of getting the right person to the training session was noted by one participant. It was felt that people who are primarily interested in wounds and wound care need to be specifically targeted.

Another participant stated that their facility felt that the toolkit could possible conflict with directives from specialist care.

### **What else would you like to add?**

Only two interviewees had any additional comments. Comments were somewhat ambivalent towards the project, although quite opposite in how they viewed the project. Participants noted the following:

*It provides great resources for less well resourced RACFs. Staff from here went out of personal interest.*

*It was a bit daunting for me as it was not what I thought it would be.*

### 3.2 Facilities Planning to Implement the Toolkit

Facilities that were planning to implement the CSI project were asked four questions about their progress towards implementation.

#### **What is your understanding of the initiative and the purpose of the project?**

Seven participants answered this question, although one participant indicated only that they were not sure of their understanding of the initiative or the purpose of the project.

A number of participants indicated that their understanding of the project was in relation to wound care, including the improvement of wound care, the better assessment and treatment of wounds and sores and to gain information and education about wound care. One participant viewed the project as relating to the promotion of healthy skin. Other participants noted issues relating to the practices of staff including the implementation of best practice and changing staff practices in wound care. A number of participants saw information and education or the building of skills and knowledge as a way to bring about improvements and changes. One participant's understanding of the project was:

*To build up skills and knowledge of staff so that they can better assess and treat wounds and sores.*

#### **Have there been any changes to policies and procedures as a result of the project?**

Of the eight participants in this group only one facility had made any changes as a result of the project. Changes involved 'an increased use of moisturisers for the lower legs'. It is interesting to note that the interviewee at this facility had previously indicated their understanding of the project to be about promoting healthy skin as opposed to wound management as noted by other facilities.

#### **What steps have you taken to implement the CSI Toolkit?**

There was an even split among facilities in this group who had taken some steps and those who had not. Time, staff leave and other priorities were reasons why facilities had not yet taken any steps to implement the toolkit. Of those who had not yet taken any steps, all stated that they intended to discuss the project with specific/key staff to start planning..

Of those who had taken some steps to implement the toolkit, one facility had engaged in initial planning meetings only. Another facility had conducted initial meetings, gathered baseline knowledge and started to develop a plan. Further action had ceased though while a key staff member was on sick leave. Another facility stated that they had done some training and accessed expert advice:

*I have trained an EN. We have a Nurse Practitioner who comes in and provides advice on practice and on serious/chronic cases.*

Staffing issues, such as staff turnover, continue to be an issue in some facilities as to why initial steps have not resulted in the implementation of the toolkit, as evidenced in the following quote:

*We did encourage the use of fluids and extra hydration after the RN attended the workshop but that is as far as we got. The RN left our organisation and didn't do a hand-over of the toolkit. It was forgotten about until Qld Uni contacted us about evaluation. I have since booked another staff member to attend another workshop early this year and we will attempt to implement after that.*

### **Is there anything else you would like to add?**

Five participants made an additional comment about the project. Two of these comments were positives affirmations about the initiative and the workshop. One participant made the following comment.

*Very good course, very interesting. Eye opener on a lot of issues*

Another participant also noted that the initiative:

*Made more people aware of these issues, especially for new personal carers. We were pleased with the day.*

### **3.3 Facilities that have commenced implementation or fully implemented the toolkit**

Of the forty facilities telephoned, 45% (n=18) had commenced implementation of the CSI project and 12.5% (n=5) have fully implemented the project. The numbers of facilities commencing or fully implementing the toolkit in metropolitan and rural/regional locations were similar (11 vs 12) and the number of small and large facilities that had commenced or fully implemented were similar (12 vs 11).

### **How are you using it / or planning to use it?**

All participants answered this question. Table 36 below provides an outline of the use of the toolkit by the facilities' level of implementation. Almost two-thirds in this group (n=21) indicated that they were using the toolkit as a resource. Thirteen participants also indicated that their facility was also using the toolkit by integrating it into resident's records. All those facilities that indicated that they had fully implemented the project had also integrated the toolkit into the resident's records. There were ten facilities that were using the toolkit as both a resource and integrating it into resident's records.

**Table 36 Use of toolkit by facility's level of implementation**

	Integrated into residents' records	As a resource	Other
Commenced	8	17	2
Fully implemented	5	4	0

Nineteen participants commented on how their facility was using the toolkit. A number of participants noted using the toolkit as a reference guide or as a product guide. One participant stated that their facility had used the toolkit in the following way:

*...development of a wound management guide that included the available products.*

A number of participants saw the toolkit as a useful resource indicating that there were a number of good resources in the toolkit. The toolkit appeared to be well utilised at one particular facility:

*...doctors ask advice about wound care and the kit is used as a resource. Nursing staff use it as well.*

Only two participants noted champions in their comments, one facility noted that they had appointed champions at each of their sites while the other had not appointed a champion. A number of participants described how their facility had made changes to procedures and approaches to wound and skin care, including updating procedures and policies to reflect the updated procedures. It was noted that some facilities took on a 'preventative approach' such as regular use of moisturisers, where indicated in the care plan, as well as 'wound care assessment' and 'wound care management'.

Training was mentioned by five participants as being an activity their facility engaged in. These included running wound management courses and skin care courses for the staff, using the CDs and other resources in the toolkit. One participant though, noted that their facility did not use the toolkit as an education resource.

Several participants indicated that their facility was using the forms from the toolkit to document and record wounds. One participant made the following statement:

*Wound management is now part of the resident's records. We have adapted some of the forms.*

It was also noted by some participants that it was the facilities practice to do a regular review/follow-up of residents using the toolkit spreadsheets.

Several participants noted that their facility already had protocols in place for wound management at their facility. One participant indicated:

*We have our own wound chart and wound management protocols at Lutheran Aged Care – they are organisational wide resources.*

Another participant noted that their facility already had a wound group in operation and another indicated that they already used a Skin Care Assessment tool. It was also noted that the CSI project was compounded by other initiatives.

One participant also noted that their facility had been delayed in their implementation due to lack of manpower but planned to refocus efforts in implementing the project.

### **Was the project implemented as intended?**

The majority of facilities (16 out of 23) indicated that the CSI program was implanted as intended at their facility.



A total of twenty participants commented about the whether or not the CSI program was implemented as intended.

For those participants who felt that the CSI program had not been implemented as intended at their facility or were not sure, they indicated either that this was because the program was only partially implemented and so they couldn't determine this yet or because the program was running behind time and so had not implemented as much of it at their facility as they had hoped. One of the reasons for this was staffing issues. One participant stated that:

*Time has affected its application - staff shortages - busy aged care sector - new RN with less experience – we would like to do things better but we do the best we can - there is only 1 of me.*

Those participants who felt the program had been implemented as intended were mostly positive about the program. However, there was some diversity in how well participants felt the program had been implemented as highlighted in the following comments:

*To the letter. Studied DVD and books. Used agendas provided. Education at staff meeting.*

*80 % implemented. Lots of other initiatives are being implemented as well. The Palliative Approach toolkit. Sexuality and dementia toolkit.*

*I only ever wanted to use it as a training tool for routine maintenance of skin - we formed a committee and tracked wounds - all part of the 3 month evaluation - this was done all in my own time and it killed me. We have no time to do the dream stuff but we have picked the best stuff from the toolkit. We also do skin education with our Medicare Local too - this is free education. We have done a lot with skin and it will be ongoing - our focus now is on pressure injuries.*

*Takes longer than anticipated. We had a lot of staff attend workshop which led to a lot of interest throughout the organisation.*

Some participants stated that they had implemented the program for a trial period and then continued with the program. Others noted that there had been good support and plenty of staff feedback about the program. Some participants noted particular practices that they had undertaken as a result of the program. One participant stated that:

*We have ensured that skin integrity is assessed on admission and reviewed regularly - the GP is involved in some cases for dermatitis.*

Another participant noted that they had seen a decrease in the rates of skin infections and pressure ulcers.

Some participants discussed difficulties they had in implementing the program as they had wanted to. Time constraints and competing priorities, including working around the needs of residents, mandatory training and additional work relating to accreditation were noted by some participants.

**Have there been any changes to policies and procedures as a result of the project?**

More participants stated that their facility had made changes to policies and procedures as a result of the project (n=13) compared to those who had not made changes (n=10) (see Table 37). There appeared to be more facilities in metropolitan areas that made changes compared to rural/regional areas. Also small facilities were more likely to make changes compared to large facilities.

**Table 37** *Number of facilities by changes made or not made by location and size.*

	Metro	Rural/regional	Large	Small
Yes	7 (30.4%)	6 (26.1%)	4 (17.4%)	9 (39.1%)
No	4 (17.4%)	6 (26.1%)	7 (30.4%)	3 (13.1%)
Total	11	12	11	12

Policy and procedure changes related to skin integrity, such as preventive measures (introducing new equipment, use of moisturisers, pressure bandages), assessment of wounds, skin and pressure injuries, regular review of original skin/wound assessments, care of skin of diabetic people and changes in manual handling to reduce skin tears.

A number of participants noted that their facility had undertaken the review and updating of old policies, some of which had not been updated for several years. Several facilities had undertaken to formalise care procedures into the care plan and patients records, noting that what should be done is made clear in the care plan.

Improvements in education were also mentioned, including the implementation of one-on-one training on the ward, using toolkit resources as posters in the ward, discussions at carers meeting and sending out memos were noted by different participants. One participant noted that a nurse champion had been appointed at their facility. This person had the responsibility of training and staff support for the initiative.

### **Has the use of evidence-based practice improved since this initiative has been implemented?**

Of those who had commenced or fully implemented the CSI initiative, the majority (82.6%; n=19) indicated that the use of evidence-based practice (EBP) had improved since the initiative had been implemented. Two participants were not sure, one participant indicated that EBP had not improved and one did not provide an answer to this question. Fifteen participants commented about what improvements had been made.

Several participants stated that their practice had changed as a result of the information provided in the toolkit, such as early identification and assessment. There were a number of changes noted related to the products staff used for skin and wound care. These included cutting down on the variety of dressings used (there had previously been confusion on what they should use) as well as now being able to order the correct products.

As a result of the introduction of new or changes to current practices some participants stated that there had been improved resident outcomes at their facility, including a decrease in wound and injury rates.

A number of participants stated that they were now using additional sources of evidence based practice, including the internet, along with the resources from the toolkit to access better ways of doing things. One participant stated that:

*The tool kit has given us more guidelines and the research to provide the best dressing for our wounds...we have learned a lot about dressings in particular.*

*...always on the internet looking at the latest up to date treatment for all conditions - staff are more aware and they have a better understanding.*

Several participants noted changes in staff awareness and understanding related to wound and skin management. Participants also discussed improvements due to taking a team approach. The use of guidelines and reference material from the kit has helped staff in their practice, for example:

*Guidelines and reference materials are providing better practice. Not just what staff know from their current or previous practice.*

*The tool kit has given us more guidelines and the research to provide the best dressing for our wounds...we have learned a lot about dressings in particular.*

Finally participants said that staff champions had been able to push through changes related to evidence based practice. One participant noted that the champion appointed at their facility was 'always seeking better ways to do things.' Some participants noted that staff at their facility tended to ask more questions and were more likely to discuss issues relating to wound management.

### **Have the knowledge and skills of aged care workers improved following implementation?**

Approximately 87% of participants (n=20) answered 'Yes' to this question. There was only one participant who did not feel the skills and knowledge of care workers had improved at their facility after the implementation of the CSI program.

Eighteen participants commented about knowledge and skills at their facility but not all participants actually discussed what the improvements had been. Those that did comment about the improvements in skills and knowledge of staff felt that wound knowledge had improved, staff were more effective at preventing wounds or were better able to handle different types of wounds.

Some participants also had commented that the improvement of staff skills and knowledge was an ongoing process or that there was still room for improvement at their facility, for example:

*They now understand the rationale for practice [but] need to understand resources.*

Several participants indicated that training may still be in the process or would happen in the future. There were a number of participants who were positive about the training, stating that those who attended had liked the training. One participant stated that:

*...this is a good resource to use for ongoing education for new staff and residents. We use the brochures in the toolkit to educate care workers and residents.*

Some participants indicated that the training and resources in the toolkit was being used in conjunction with other training, such as in-service training. Participants felt that for those who had attended the training it had prompted them to think about certain areas, such as pressure injuries and prevention.

Some participants felt while some staff did have more skills and knowledge that this was not so easily transferred to all staff. Some of the reasons for this was a lack of time to train compounded by an ongoing need to reinforce messages, or that access to the toolkit was limited to lower level staff. One participant stated that:

*The CSI champions have considerable knowledge but sometimes feel overwhelmed by the demands.*

### **Has clinical leadership improved due to the implementation of this tool?**

Response to this questions was slightly less favourable compared to the previous question but was still largely positive. Only 74% of participants (n = 17) answered yes to this question. Thirteen per cent of participants (13%, n = 3) did not feel that clinical leadership had improved as a result of implementation of the toolkit and another 13% were not sure.

Only four participants commented about why clinical leadership had not improved at their facility. For some it appeared that it was too early in the process for this to have occurred. One participant noted that new graduate staff would require time to gain experience. Another participant did not feel that improvements could be directly linked to the toolkit.

The remaining participants who commented about improvements in clinical leadership either discussed their own improvement in clinical leadership skills or the leadership skills of other staff such as RNs and ENs. Those who had improved their own clinical leadership skills discussed their efforts to be a champion by gaining support from the educator and directing how the toolkit was used. This included improving their own awareness about wounds, passing on knowledge to other staff and being more aware of what is happening with all residents in regards to wound management.

Those who discussed the improvements in clinical leadership skills noted that that training and improved knowledge lead to an improvement in staff confidence as indicated in the following comment.

*The EN has more confidence in decision making. RNs have enhanced knowledge. They are more proactive.*

It was also noted that assigning specific people as champions for other staff to come to for information has also improved clinical leadership.

### **Have staff been supported in accessing and using evidence based practice?**

Almost all participants answered yes to this question (96%, n= 22), with only one participant indicating they were not sure.

When asked how staff have been supported, 18 participants responded. Training was the most popular form of support mentioned (n= 9). This included increasing the amount of training provided, e.g. training during staff meetings, as well as increasing the number of education resources available to staff. One participant stated that:

*Clinicians now have more confidence in teaching – the resource is a great backup - it adds substance to the teaching.*

New practices implemented to promote access to EBP included handing out new handover information at shift changes as well as undertaking new review processes and looking for new evidence based practices. One participant also indicated that providing training and information to staff has set up an enquiring culture and staff are eager to learn more fostering a culture of evidence based practice.

### Does this initiative involve the use of extra resources?

For this question participants were given a choice of answers, as outlined in Table 38 below. Participants could choose one or more answers.

**Table 38**      *Extra resources needed by type of resource for facilities implementing the CSI program*

Extra Resources Needed	Number
Staffing	11 (48%)
Administration	9 (39%)
None	8 (35%)

Additional staffing resources were the most common extra resources used, although over a third of participants indicated that no extra resources had been needed at their facility. Just over 65% of participants (n=15) commented about the extra resources they used.

For those who indicated that they had used extra staffing resources only six participants generally discussed the extra staff time required to implement the project, this included training time, such as going to workshops or doing internal training, and implementation time. In regards to implementation time, a number of participants noted that for some staff there had been initial concerns about the time to do additional tasks, such as applying moisturisers or photocopying resources, but this was offset by the reduced time taken to provide care in the longer term due to a reduced number of wounds, better healing and better skin condition, for example:

*Staff were concerned about time taken to use moisturisers but are now getting better healing times and less skin tears so less work in the long run.*

For those who commented about the use of extra administrative resources only (n=4), photocopying of resources was discussed as well as the production of additional resources such as newsletters. Comments were largely positive about the extra time needed to implement the program, as stated by this participant:

*The initial steps to set up the toolkit takes time but once the system is established it is seamless.*

For participants who indicated that implementation required both extra staffing and administrative resources (n=5), training was again indicated as a significant contributor to extra staff time. Additional staff time was also taken up by attending meetings, photocopying and the development of plans. The purchase of additional resources was also noted by several participants, including the purchase of additional dressings and setting up of extra kits, the purchase of more special mattresses and expenses related to other unspecified extra equipment.

### **Have there been any unintended consequences for your organisation arising from the initiative?**

For this question participants were given a choice of answers. They could select either 'positive', 'negative' or 'none'. No negative consequences were observed. Eleven respondents selected 'positive' consequences and another 11 selected 'none'.

Participants were given the opportunity to comment about any unintended consequences. Only those who had noted positive consequences went on to comment about them. Some of these consequences, though unexpected for the participants, were probably not unintended consequences in relation to the program. These included improvements in serious wounds, the number of wounds and other skin damage. Some staff noted that residents were also happy with the extra attention and/or information given to them. One participant noted that the implementation of the program had highlighted their facility did have an issue with skin integrity and this was now being highlighted earlier and managed quicker. It was also noted that there had been a cost benefit for the organisation as well as time savings for staff and residents. Increased interest from carers was also noted as a result of now being able to use the clinical tools.

### **Do you think that you can keep this initiative going?**

For facilities who were currently implementing the CSI program, almost all (n=21) felt that their facility could keep the initiative going. Two participants were not sure.

Participants were asked to comment on their answer with 15 participants providing details about how they would keep the initiative going. The majority of participants indicated that they would keep the initiative going by building the program into normal practice. One participant stated that:

*This is what we do now - we could do better but the resources are there and we all use them. The knowledge and interest in wound care has improved.*

Another participant stated that their organisation was planning to take the program one step further to the organisational level:

*We are embedding it into the organisation's clinical governance model rather than leave it to individual managers.*

Some participants provided detail as to what actions they were planning to take to continue the program, including maintaining a champion for the program, continuing with

management support, reviewing practices and updating staff on changes, developing internet resources and continuing to send people to training.

Some participants appeared to be little less certain about keeping the program going in their comments in spite of initially answering yes. These noted staff changes as a challenge or were planning on only keeping the toolkit as a resource only.

### **Are there barriers to the sustained use of this initiative?**

Approximately 74% (n=17) of those participants from a facility implementing the CSI program said 'Yes' to this question, 22% (n=5) said 'No' and 1 participant did not answer the question. Of this group, 69.5% (n=16) provided details on what they thought those barriers were.

Staffing issues was seen as the main barrier to the sustained use of the initiative. These included staff turnover and having to train new staff, a lack of staff or a lack of staff time due to competing interests, and staff attitudes to the program such as resistance to change.

Financial limitations were mentioned by some participants, mainly relating to the purchase of equipment and resources such as dressings.

Wider organisational factors were also seen as a barrier to sustained implementation. For example, one participant noted that:

*New online system that our organisation is moving towards may not support this tool.*

### **Have you learnt any lessons from this initiative?**

Approximately three quarters (74%, n=17) of participants whose facility was implementing the CSI program felt they had learned lessons from the initiative. Just over 17% (n=4) felt that they had not learnt any lessons. One participant each was either not sure or did not answer this question.

Participants were asked what lessons they had learned and 18 provided details. Four participants felt that the CSI toolkit was a very good resource, stating that it was simple and easy to use, such as the classification charts and thought that it was good that the resource was available to everyone.

There were a number of comments indicating participants had appreciated what they had learned about wound care. Wound prevention was mentioned several times by participants. One participant stated that:

*It made me look at more preventative methods rather than curative.*

Other participants discussed the benefits they had received from learning about wound management, For example:

*We have learned a lot about wound management particularly about dressings and reinfection - we have a consistent approach now.*



One participant indicated that their facility had taken wound management one step further and had purchased equipment to assist diagnosis and treatment:

*Really important to keep up with evidence based practice. We have purchased a Doppler machine to determine type of ulcer and assist with diagnosis and treatment.*

Learning about the implementation management process was also discussed by a number of participants. Some important lessons noted by some of these participants, included not taking on too many projects at once, personal organisation and time management skills, planning and the need for key staff to drive and control the process. In regards to these points, one participant stated that:

*This maybe not so easy in larger facilities - may not all be working to achieve the same goal.*

One participant made a particular point regarding all of the aspects of managing the implementation process that need to be considered:

*We need 20 of me - there are many toolkits out there and we get inundated - e.g. palliative care - plus ACFE stuff and quality stuff and audits and accreditation. We do the best we can do. We need an educator dedicated to these sorts of initiatives. Staff turnover and English language skills are all challenging. There are many barriers to education - there should be more funding for more educators. Education must be face to face and not online.*

Some participants noted that resistance to change was an issue at their facility. Initial resistance to change was overcome over time and with persistence, especially where there are established practices that need to be changed. Maintaining the interest in wound care was noted as an important way to overcome resistance, as shown by this participant:

*You need to be a motivator - you need to get the staff interested in wounds - you need to sell the toolkit. Wound management needs to be constantly on their radar.*

Some participants also discussed things they had learnt regarding training. One participant felt there needed to be a 'train the trainer' model of training, another stated that a culture of 'learning all the time' was important. One participant noted the importance of sending more staff to training, as shown in the following statement:

*It was good to have lots of staff attend the second round of workshops as they reinforced each other's work.*

### **Do you think the aged care sector is receptive to the use of evidence-based practice?**

Participants either answered 'Yes' to this question (n=20, 87%) or were 'not sure' (n=3, 13%). No participants thought the aged care sector was not receptive to the use of evidence-based practice.

All but one participant gave details as to why they thought this. There were a number of comments with a positive view of evidence based practice as it is seen as leading to improvements in care and improvements in outcomes.

Accreditation also appeared to be a driver for the uptake of evidence-based practice and changes within the industry. This was viewed both positively and negatively, with some seeing it as something they had to do, proof was needed for everything that was done in the



facility and they must show what they were doing was right. One participant felt there was 'possibly too much regulation'. Other participants viewed accreditation as something that was driving evolution within the industry. One participant noted the following:

*The sector is both ready for change and the toolkit fits in with accreditation.*

It was noted by several participants that there was a mix in receptiveness to evidence-based practice at both the facility level and/or at the staff level. It was felt that some facilities were more receptive than other. One participant noted that rurality may be a barrier, as shown in the following comment:

*Not all RACFs are onto evidence-based practice. There are restrictions on rural and remote RACFs that are limited in access to support.*

Some participants noted that newer staff were sometimes more willing to learn and some older staff were less willing to change. Change was also seen as difficult to bring about when there were few higher trained staff overseeing a large number of less well trained care staff. Some participants felt that receptiveness to evidence-based practice was improving over time. This may be due to more highly trained staff as implied by the following comment:

*It is becoming more receptive. Open to new ideas - tertiary qualified nurses are now being taught how to research and find information.*

#### **Do you see any future needs for wound management in RACFs?**

Approximately 75% (n=17) of participants did see future needs for wound management in RACFs, three participants (13%) did not see any future needs and one participant (4%) was not sure. Two participants did not answer this question.

There were 18 comments from participants about what they saw as the future needs for wound management in RACFs. A large number of these comments related to ongoing staff training. It was seen that there was a need for education for new staff, including general care staff, nursing staff and doctors as well as regular updates and refresher courses. Training should be affordable or free of charge and provide a consistent message.

Access to expert services or specialist care was also discussed by some participants as being a need. This would help facilities in getting consistent messages across to staff and families. It was also felt this would help champions by allowing them to 'bounce ideas' off the experts.

Economic support was also a point made by several participants, including financial support for training and the purchase of products such as dressings and equipment.

There were system level issues that were also brought up by some participants relating to residents who need external care, as shown in the following comments:

*The toolkit should also be used in the acute care system. A couple of returning hospital patients have had bad pressure wounds.*

*Biggest worry for the RACF is sending people to acute facilities without the equipment and support. People with fractures are at high risk of black heel and coccyx injury. Who's tracking them in acute care? There is a breakdown in continuity.*

One participant argued for improved access to wound care through an annual review of wounds:

*Everyone needs access to wound care nursing advice - most hospitals have annual medication assessment reviews - this should be the same with wound management.*

Other systematic issues related to the need for wound management programs to be spread to all RACFs and the need for streamlined process and more sharing of information in regards to evidence based practice.

#### **Is there anything else that you would like to add?**

Only nine participants (39%) had further comments that they wished to add. A number of these were positive relating to the value of the program and the usefulness of the workshops and the toolkit. One participant stated that:

*It is a good initiative and important to have a national approach so that there is consistency in the sector. Exposure to education is important. Residents are more complex and have more skin issues than previously thought.*

One participant commented about the needs in remote locations:

*We are a very remote site. Workshop attendance is difficult and it is very expensive to travel. Remote areas need extra support. We need assistance post workshop too. Trainers could come to the site rather than the other way round.*

One participant noted they were also getting support from a local wounds management team from the local health district, which may be something other areas could consider.

## **4 Palliative Care Approach Toolkit: Telephone Interview Results**

A total of 31 interviews were conducted with representatives from aged care facilities who sent staff to Palliative Care toolkit training. The final sample of interviewees included participants from all states and territories. Attempts were made to recruit additional participants, however, the target of 40 participants was not reached.

Table 39 below provides an outline of numbers of participants from each state and territory, their geographic location and facility size. Good representation was achieved across all categories.

**Table 39** *Participants by state*

State	Number	Rural/Regional	Metropolitan	Large	Small
NSW	7	4	3	4	3
NT	1	1	0	0	1
Queensland	7	3	4	4	3
SA	3	2	1	1	2

State	Number	Rural/Regional	Metropolitan	Large	Small
Tas	3	1	2	1	2
Victoria	6	3	3	4	2
WA	4	2	2	2	2
<b>Total</b>	<b>31</b>	<b>16</b>	<b>15</b>	<b>16</b>	<b>15</b>

Participants were asked at what level of implementation their facility was at in regards to the Palliative Care toolkit. Table 40 provides an outline of the level of implementation by state. Over a quarter of facilities (25.8%) were planning to implement the toolkit but there was also a substantial number of participants (22.6%) whose facility had no plans to implement the toolkit. Just over half of facilities had either 'fully implemented' or have 'commenced implementation' (n=16).

**Table 40** *Level of implementation by state*

	NSW/ACT	NT	Qld	SA	Tas	Vic	WA	Total
We have fully implemented the toolkit	1	-	1	-	-	-	1	3 (9.7%)
We have commenced implementation	3	-	4	1	1	3	1	13 (41.9%)
We are planning to implement it	2	1	2	-	-	2	1	8 (25.8%)
We have no plans to implement it	1	-	-	2	2	1	1	7 (22.6%)
<b>Total</b>	<b>7</b>	<b>1</b>	<b>7</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>31</b>

Table 41 compares the level of implementation between metropolitan and rural/regional facilities. Metropolitan facilities appear more likely to be implementing the toolkit (commenced or fully implemented, 35%, n=11).

**Table 41** *Level of implementation by location*

	Metropolitan	Rural/regional	Total
We have fully implemented the toolkit	2	1	3
We have commenced implementation	9	4	13
We are planning to implement it	2	6	8

	Metropolitan	Rural/regional	Total
We have no plans to implement it	2	5	7
<b>Total</b>	<b>15</b>	<b>16</b>	<b>31</b>

#### 4.1 Facilities with no plans to implement the toolkit

Interviewees who indicated that their facility had no plans to implement the CSI toolkit were asked six questions. These related to their understanding of the project, why they were not implementing the toolkit, barriers to implementation, the future needs of palliative care in RACFs and any other points they would like to add.

##### **What is your understanding of the initiative and the purpose of the project?**

Only four participants provided an answer to this question, of which two knew nothing about the toolkit and one wasn't sure. Of those not planning to implement the toolkit there appears to be little understanding of the toolkit itself.

##### **Why do you not intend to implement the Palliative Care Toolkit within your facility?**

All participants in this group provided details about why they were not planning to implement the toolkit. The most common response was that facilities in this group felt they already had most, or all, of what the toolkit was offering. Some participants indicated that they had used some parts of the toolkit to cover gaps in their system or that it reinforced what they were already doing. One participant made the following statement:

*We are currently using the gold standards framework along with four other local facilities. This has provided us access to a lot of education through the local specialist palliative care service. We attended the workshop to make sure that our model of care was on the right track and to check what resources were available. The workshop was very professionally run and the resources supporting the toolkit are fantastic. We particularly like the bereavement support booklet for staff.*

The remaining participants indicated that either it was because they did not know about the program or that they had only sent one staff member and they had since left the organisation.

##### **What do you see as the main barriers to implementation within your facility?**

Once again, all participants provided a response to this question. Participants had different views on what the barriers were, including a lack of resources, lack of knowledge about the program and staff turnover. One participant indicated that a lack of staff was the main barrier:

*The lack of registered nurses in some facilities - particularly in low care facilities. It is a great toolkit and would put facilities on the right path but it needs people to drive the change.*

Another participant felt that the barriers were more systemic in nature:

*Everyone needs to be on the same 'page' - at the moment the GPs seem to be lacking knowledge of current developments in palliative care. Like everyone in RACFs we are admitting residents at a later stage with more complex needs - palliative care is becoming increasingly relevant and we need to be able to do this well.*

### **Do you see any future needs for palliative care in RACFs?**

Only three participants in this group answered this question, of which two answered 'Yes' and one was 'not sure'. Two participants provided feedback about this question with one participant noting that while there is a lot of palliative care education for nursing and care staff, GPs needed more training, as indicated in the following statement:

*GPs tend to miss out and their prescribing regimes seem to be old fashioned - they need much more support.*

A second participant felt that there were needs relating to pain assessment and access to specialist services.

### **Is there anything else that you would like to add?**

Participants made several additional comments of which some were positive statements about the workshops and the resources in the toolkits. One participant noted that while they had used the toolkit in the past they now mainly used other resources. Another participant indicated the need for one-on-one education with all staff and the need for psychosocial support for all staff, including grounds people and cleaners, to deal with issues relating to bereavement.

## **4.2 Facilities who are planning to implement the toolkit**

There were eight participants who were planning to implement the toolkit. Participants were at various levels of planning. Some facilities had not yet done anything and indicating that implementation was something they would like to do. Other facilities had undertaken several planning tasks and one facility was about to start internal staff training in the first quarter of 2015. This participant, having completed a number of planning tasks and being about to implement the program, was analysed along with those who had commenced implementation as they were all able to answer many of the additional questions for this group. These seven participants were asked four additional questions.

### **What is your understanding of the initiative and the purpose of the project?**

All seven participants analysed in this group answered this question. Of these only three were able to provide details on their understanding of the initiative. Their understanding was that the initiative was to help staff to better understand symptoms and palliative processes and therefore provide better care to residents, to provide a forum for discussion, education to nurses and to provide resources, through the toolkit, to support palliative care in RACFs.

Other responses addressed barriers to implementation such as lack of staff time, competing priorities, staff turnover and a perceived lack of need due to links with local specialist palliative care services and the local health district.

Other participants indicated that, as they were part of a larger organisation, it was organisational policy to roll-out the toolkit during 2015. They would be adopting the toolkit as a matter of organisational policy.

### **Have there been any changes to policies and procedures as a result of the project?**

All participants in this group answered 'No' to this question and did not provide any details in relation to their answer.

### **What steps have you taken to implement the Palliative Care Toolkit?**

Respondents to this question (n=6) did not identify a lot of activity towards planning for the implementation of the toolkit in the future. Half indicated that any planning or other activities towards implementing the toolkit would be happening at some time in the future. One participant stated that implementation was being discussed at a higher level within the organisation. Another participant indicated that a staff member had been identified to implement the initiative.

Two participants indicated that planning activities were taking place at their facility. For example one participant stated that there were two nurses currently working to implement the program.

Of those participants who indicated that they were planning to implement the program, only one had done significant work towards implementation. All other facilities in this group provided only a few details on their plans for implementation, such as assigning staff members to work on the implementation and investigating local training options.

### **Is there anything else that you would like to add?**

Four participants in this group provided extra comments about the palliative care toolkit initiative. There was a wide variety of responses. One participant thought the toolkit was 'a great resource', while another stated they were frustrated at slow bureaucratic processes. A third participant reiterated the importance of palliative care in aged care and the need for greater awareness and early intervention. One participant felt there was not a great need for the toolkit, as summarised in the following comment:

*I believe that we are already delivering quality palliative care - 2 patients in the last couple of months - we get great feedback from families. Our staff have attended many pall care in-services and are competent in this area.*

## **4.3 Facilities that were currently implementing the Toolkit**

Participants in this group included both those whose facility had commenced implementation, including one facility that was about to commence implementation and had done significant work in that direction, and those whose facility had fully implemented the toolkit. There were 17 participants in this group.

### **How are you using, or planning to use, the toolkit?**

Overall, equal numbers of participants indicated that their facility would be using the toolkit as both a resource and integrated into resident's records (see Table 42).

**Table 42**      *Use of the toolkit by level of implementation*

Level of implementation	Integrated into residents records	As a resource	Other
Fully implemented	2	1	0
Commenced implementation	7	8	2

Most participants in this group (88%, n=15) provided details about how they were using or planning to use the toolkit. A number of participants indicated that their facility was integrating the toolkit into the resident's records. This included advanced care planning, using questionnaires and assessments from the toolkit, including 'family and doctor questions', 'Pal Care Assessment', 'advanced care directives' and 'comfort care charts'. Several participants stated that they were using the end of life pathway. Other participants indicated that the tools had been uploaded into the patient management system where outcomes were recorded.

One participant noted several ways in which the toolkit was being used a their facility

*We are doing advanced care planning with all new admissions - it is now part of our initial assessment - we are using the toolkit for case conferencing and outcomes are included in the residents chart and uploaded into the resident management system.*

Another participant indicated how well the toolkit was integrated into practice.

*It is a key part of the care plan and assessment of end of life care. The care pathway is excellent and we use it all the time.*

Many participants also stated that the toolkit was being used as an education and training resource at their facility. Some participants stated that their facility had employed someone to conduct training in palliative care while other participants had taken on the training themselves. Some participants stated that the toolkit was used in conjunction with other training in palliative care, as outlined in the following statement:

*It is a very good resource - a lot of info about getting things done and sorting things through the various palliative stages - a good educational tool. It is just one component of palliative care training that we use - we are closely linked with the local specialist services.*

Some participants indicted the toolkit had promoted team work within their facility, including the use of case conferencing, Link Teams and the appointment of a multidisciplinary committee, as outlined by one participant.

Another aspect of the toolkit that was mentioned included the use of the flipchart with families. Some participants also noted the uptake of recommendations for implementation including the appointment of champions, while others noted the ways that the toolkit was being integrated with existing systems such as 'respecting patient choices forms.'

### **Was the project implemented as intended?**

The majority of participants felt their facility had implemented the project as intended (71%, n=12).

Of those who provided feedback about their implementation of the project (n=15), two participants indicated their facility had fully implemented the project and stated that they had implemented the project as planned. They were positive about the experience, one indicating that the toolkit had reinforced their practices and the other providing examples of how they implemented the project with some positive organisational outcomes:

*We put together a pall care team beforehand including RNs and a project manager. It has been implemented as intended - we have followed the guidelines and have completed after death audits - we have used the EoL care pathway and advanced care plan which has now been adopted by Blue Care more broadly.*

Of those who had commenced implementing the project, the majority (53%, n=9) stated that the project had been implemented as planned. The remaining participants (24%, n=4) stated that the project was not implemented as planned.

Of those who had commenced implementation of the project and had indicated that the project was implemented as planned (n=9) some still indicated there had been some problems with implementation, including delays due to bureaucratic processes, staff turnover and competing priorities. Some of these delays were overcome through input and support from local specialist palliative care services and others due to staff knowledge of the toolkit and palliative care. One participant stated that their facility had not intended to implement the project fully as outlined in the toolkit.

Those participants who felt the project was being implemented as planned discussed issues such as having a plan and sticking to it, requiring good management support for the project, staff training and engagement, having enough trained staff to fill key roles during periods of vacancy and the need for external specialist support.

Another 24% (n=4) of participants felt that the project was not implemented as planned. Comments from participants showed that even though they felt the project hadn't been implemented as planned some still indicated a largely positive experience while others commented about specific barriers.

Other participants who noted barriers to implementation discussed delays related to staff turnover with new staff having to implement the program without having attended the workshop. Another barrier discussed was mainly about bureaucratic and legal issues of changing old practices, as stated by this participant.

*We have not implemented to the degree that I planned to - it comes down to head office and how much they support moving away from existing systems and moving to the pathway - trying to get support for the ACP has been tricky - need to change policies at an organisational level. The legal issues re ACP are complicated for the organisation - head office are currently getting legal advice.*

**Have there been any changes to policies and procedures as a result of the project?**



Nine of the 17 projects (53%) indicated that their facility had made changes to policies and procedures. This included both those who had commenced implementation and had fully implemented the program. Those who indicated that their facility had not made changes to policies and procedures were all from facilities that had commenced implementation but not yet fully implemented the program.

A number of participants (n=11) commented about the changes that their facility had made. The most common changes related to the introduction of care planning and the use of the end of life pathway. In particular, discussions with residents and family about care planning and end of life from admission were either introduced or reviewed and reinforced. One participant stated that:

*We are now looking at the whole care planning process - prior to the toolkit we did have a care plan which we are still using but we are fine tuning it to suit based on the toolkit. Care planning is now part of procedure and respecting patient choices - we see these as synonymous. We openly discuss end of life decision making - our staff have been trained. We now have earlier identification of palliative care patients and less rescuing.*

The importance of case conferencing and including GPs in discussions was mentioned by three participants as now being part of routine practice. Others indicated that discussions with family about care planning and end of life care were now happening earlier at admission. Participants also noted changes related to the recording of care plans and other information in a patient held record, formalising practices into routine practice, as stated by this participant:

*The tools now form part of the patient held record and the computer management system - it has changed the way we operate - all residents must now do a case conference and have an advanced care plan - this is now part of the patient's documentation.*

### **Has the use of evidence-based practice improved since this initiative has been implemented?**

Fourteen out of 17 participants (82%) thought that the use of evidence-based practice had improved in their facility. Only participant felt that it had not improved and two were not sure.

Thirteen participants provided feedback about the use of EBP in their facility. The majority of feedback related to the use of the toolkit by staff. Participants indicated that the use of the toolkit had been helpful in promoting a consistent documented approach. This has promoted confidence and teamwork, as this participant states:

*Our staff are more confident in what they are doing and RNs have a better understanding of advanced care planning and pain management. The EoL pathway encourages team work.*

Some participants noted gaining expertise through avenues other than the toolkit. The Joanna Briggs Institute was mentioned but also local specialist palliative care services have also been accessed for training and information support.

### Have the knowledge and skills of aged care workers improved following implementation?

Participants who answered this question (n=16) mostly indicated that the knowledge and skills of aged care workers at their facility had improved following implementation (n=14; 82%). One participant felt that skills and knowledge had not improved and one was not sure. All participants who felt there had been improvements also provided details.

Most participants felt that there had been an increase in the knowledge and skills of aged care workers. Evidence for these improvements was clear in some cases, with positive feedback from residents and families:

*We have had extremely positive feedback from families about palliation. The toolkit helps this and the training we offer staff is important too. Palliative care is a key focus for us. We are building a caring team.*

Some participants discussed how staff confidence had also improved as a result of the improvements in skills and knowledge, for example:

*Compared to 12 months ago we are more certain as to what to do with our palliative patients. Now staff are more confident and they are more independent and less reliant on RN advice.*

Some participants felt that improvements had occurred at all levels of staff, including RNs, ENs, AINs and other staff. Several participants gave examples of staff within their facility that's had improved their knowledge and skills.

*...we have nominated AIN champions too and provided education for all.*

*This is across all disciplines - and hospitality staff. We use the toolkit as an educational resource.*

Other participants indicated that the improvement in skills and knowledge had not necessarily occurred for all levels of staff. In particular some participants had stated that while more senior staff had improved their knowledge and skills other staff, such as AINS and other care staff had not yet been trained or were still in need of training.

A number of participants detailed training efforts that had been undertaken to improve skills and knowledge, such as employing a staff educator. One participant provided an example of extra steps taken to ensure training had been successful:

*I conducted an informal survey recently about palliative care and I was happy with staff development in this area - it also provided me an opportunity to conduct a needs analysis for training gaps.*

Several participants also outlined how staff skills and knowledge had improved by use of the toolkit and training in practical situations. Appointing champions appears to have provided the opportunity for specific staff to develop other skills, such as leadership skills.

*The champions work really well - they are resource people - the champions take on responsibility of patient care and mentor staff.*

Only one participant stated that skills and knowledge had not really improved but this was because they felt that staff were already knowledgeable.

### **Has clinical leadership improved due to the implementation of this tool?**

Almost all participants in this group responded with a yes to this question (n= 15, 88%). Only one participant did not think clinical leadership had improved but did not provide any details about this. One participant was not sure. Twelve participants provided feedback about these improvements.

The majority of feedback about clinical leadership was positive. There appeared to be a link between knowledge and confidence and the promotion of clinical leadership, as outlined by one participant:

*We have come a long way in palliative care - The EOL pathway is a great tool to manage residents in a timely fashion. It has made service delivery a lot easier for care staff. The RNs now have confidence to start up the pathway independently. There is less reliance upon management as a result.*

Other participants discussed how knowledge had given them confidence in conducting case conferences, noting that these were openly supported by clinical leaders. The appointment of palliative care champions was also noted as assisting with clinical leadership.

Some participants felt that clinical leadership was still lacking at their facility or that clinical leadership had not necessarily been linked to the implementation of the toolkit. One participant stated that a lack of staff confidence was an issue:

*We're still driving it from the clinical care office. Personal carers are still not confident enough to take the initiative, especially over the weekends. We still have some way to go due to a lack of confidence of staff.*

Some participants felt that whilst the toolkit had the potential to improve clinical leadership this had not happened yet or was not specifically related to the toolkit.

### **Have staff been supported in accessing and using evidence based practice?**

Approximately 94% (n=16) of participants in this group stated that staff had been supported in accessing and using EBP. Only one participant indicated that they were not sure. Thirteen participants discussed how staff had been supported.

The three main areas that participants discussed that supported staff in using EBP was in providing training, providing resources, either from the kit or through access to internet resources or media resources, and through management/organisational support. Organisational support was identified as particularly crucial.

Lack of time was identified by one participant as a barrier to EBP:

*But enabling EBP with the appropriate amount of time required is challenging in the busy RACF sector.*

### **Does this initiative involve the use of extra resources?**

Eleven participants in this group indicated that extra staffing resources were involved in implementation and eight indicated that no extra resources were required for implementation. No participants indicated that extra administrative resources were used.

Two participants indicated both 'staffing resources' were involved and 'no resources' were involved.

Several staff stated that there had been internal reassignment of time or extra roles taken on by staff. This included, for example, a day a fortnight reassigned to care for palliative care patients, or educational staff also taking on a support role. It was noted that some staff assigned as champions had used their own time to learn more and familiarise themselves with the toolkit or senior staff with expertise in palliative care had provided after hours consultative time.

Rather than use additional staff time for some aspects of the project, some facilities had accessed external support from external services and specialist teams. These services and teams have been involved in consultation visits, care planning and ongoing support. One participant noted that this has promoted more networking among local services.

It was noted that some activities take more time than expected, these included time to deliver training, however it was also noted that trained staff also saved time in the long run. Case conferencing was also seen by one participant as taking more time as there were more stakeholders involved and this needed more planning and administrative time.

### **Have there been any unintended consequences for your organisation arising from the initiative?**

Ten respondents indicated there had been positive unintended consequences while seven stated there had been no unintended consequences. No participants indicated that there had been any negative unintended consequences.

A total of seven participant provided feedback about the positive consequences they had observed as a result of the initiative. A number of participants noted that they had received very positive feedback from families about care, including the care provided at the end of life. One participant discussed the way that families were also getting involved and the positive results from this:

*Fits in well with respecting patient choices - we have had an overwhelming positive response from families that they want to complete paperwork - 90% of residents have completed forms for respecting patients choices and the toolkit. Now residents are more likely to die at the RACF as per their requests.*

Some participants also talked about how the toolkit had been well received and the palliative approach taken on with enthusiasm by staff. One participant did discuss an issue that they had with some aspects of the toolkit in regards to the size of some of the resources:

*The toolkit is a good background resource. The flip charts are great but the A3 size is too large though. We have limited space in the resident's rooms. Where are we going to put it? It may not be appropriate to be in the room anyway?*

### **Do you think you can keep this initiative going?**

All 17 participants in this group indicated that they would be able to keep the initiative going. Of these, 12 participants provide details about why they would be able to keep it going.

A number of participants stated that the reason they would be able to keep the initiative going was because they had built it into routine practice with some saying 'it's part of what we do'. One participant focussed on how their facility would be continuing with the initiative:

*It is part of the way we do things now - we are now focussing on resources and purchasing equipment to support palliative care - in recent performance reviews for staff many have requested more palliative care education.*

Another participant indicated that the reason the initiative would continue was because there was staff engagement with the initiative and organisational support.

Some participants, who indicated that they had commenced implementation but not yet fully implemented the project indicated that they would be increasing their activities in relation to the initiative, such as using more of the toolkit resources with residents to promote advanced care planning and case conferencing.

There were some participants who indicated that they would continue with the initiative but perhaps at a level lower than previously, such as using the toolkit as a resource only.

It was also thought that while the toolkit would remain valuable in the short term it would need to be updated with regards to any future revisions of the therapeutic guidelines.

### **Are there barriers to the sustained use of this initiative?**

Among those facilities who were implementing the initiative almost 60% (n=10) of participants stated that there were no barriers to the sustained use of the initiative. These facilities included both facilities that had fully implemented the initiative as well as those that had commenced the initiative. Seven participants did indicate that there were barriers to the sustained use of the initiative. All of these participants were from facilities that had commenced implementation only.

A number of participants (n=9) provided details about the barriers to the sustained use of the initiative. There were a range of issues discussed by participants. Barriers were related to organisational and staff issues or to family and culture.

Organisational barriers related to time required for case conferencing, inability to respond quickly enough to resident's changing condition, i.e. having 'everything in place', particularly on the weekend, staff turnover and the need to train new staff. One participant also noted some organisational resistance to the use of case conferencing and care planning:

*The main barrier has been advanced care planning and case conferencing - there is some hesitation about legal issues from upper management e.g. power of attorney issues...legal implications.*

Another participant also indicated there was resistance from some GPs in regards to new practices:

*GPs - some are positive but others aren't - pain management is an issue as some GPs are very traditional in their approach.*

Family decision making was also noted as a barrier but appeared to be mainly a barrier for staff rather than the implementation of the program. Families may make decisions based on their own priorities and perceived needs. They may decide to hospitalise their family member or they may be reluctant to have end-of-life discussions with their loved ones.

Cultural issues may be an area where the initiative may need to be modified as evidenced by the following statement:

*It needs to be targeted to different audiences in RACFs due to different educational and cultural backgrounds of workers, e.g. some Greek communities have Greek only RACFs. It needs to be sensitive to other cultures as the death and dying process can be culturally specific.*

### **Have you learnt any lessons from this initiative?**

All participants felt that they had learnt something from the initiative. All participants also provided feedback about the lessons they had learned.

Several participants discussed the need for commitment to the initiative from all relevant parties, including staff and management. Planning, training, management structures and ongoing support were also necessary for successful implementation. It was noted that in larger organisations, bureaucratic process can be an issue to rolling out the program:

*Implementation is not as simple as bringing it back and rolling it out. It needs approval from the organisation and needs to be trialled first. We have learned a lot about palliative care but it has been a bureaucratic mine field. There has been some resistance from head office.*

In addition to this, communication with staff was also seen as important and may need to be improved in some cases.

Several participants felt that they had learned a lot about a palliative approach from the toolkit and from training workshops. This included understanding the importance of palliative care, advanced care planning and learning about the toolkit and using existing resources. It was thought important that staff received plenty of training and that resources such as the toolkit did not 'gather dust on the shelf'.

Many participants discussed lessons learned in relation to working with families. These included the importance of family involvement, being clear on what residents and family want, preparing for the end stages and minimising distress for families. Personalised care and a focus on the resident's wants and needs was also noted as important, as outlined in the comment below.

*It is very much about focusing in on what's important for the resident. We have to listen to what the resident wants and not do things for the sake of it.*

In addition some participants felt that it was important to provide education to families and friends of residents, including education about the different palliative care stages.

Lessons learned included the need for a commitment to the initiative at all levels as well as planning, training and good management and support. Addressing any wider organisational factors or requirements should also be taken into account in planning. Communication with staff is also an important aspect of planning.

The training workshops and toolkit resources appear to have been valued by some participants, indicating that they had learned much from these. Continuous learning and quality improvement was also important.

Working better with families and residents was also a topic where participants felt they had learned lessons. Much of what was discussed appeared to be about allowing families more involvement and providing informed consumer directed care.

### **Do you think the aged care sector is receptive to the use of evidence-based practice?**

All but one participant (n=16) felt the aged care sector was receptive to the use of evidence-based practice (EBP) with one participant indicating they were not sure. Twelve participants provided feedback about their answer.

Most participants discussed their own receptiveness or the receptiveness of their facility in relation to EBP. Some participants indicated that their facility was involved with actively looking for 'better ways to do things' and updating their policies and practices to reflect EBP.

Some participants felt that not all facilities were receptive to EBP. It was noted that complicated paperwork could be a barrier as well as staff who were not committed to the initiative, for example:

*In some ways yes and in some organisations. You need passionate people in aged care. Some are filling in time before they retire. It is a complex area to work in and you get out of it what you put in.*

Most participants felt that they and their facility was receptive to EBP but some participants felt this was not the case in all facilities or organisations.

### **Do you see any future needs for palliative care in RACFs?**

Fourteen participants identified future needs for palliative care in RACFs and only three participants did not see any future needs. Most participants (n=15) provided details about their answer.

One participant who thought there were no future needs still felt that ongoing support and training were important so as not to lose the knowledge as the staff change.

Those participants who thought there were future needs had a range of issues they felt needed to be addressed. Ongoing training was identified as an area of importance to maintain the program as discussed by the following participant.



*We need to provide more training to RNs so that they are capable of delivering a palliative care approach rather than the palliative team. We also need one palliative care specialist per facility. Then there would be no waiting for an external specialist palliative care team to come into the facility to manage the resident. This way the resident is less likely to go to hospital. We need an advanced palliative care nursing program in resi aged care.*

On the other hand, one participant thought that more support from palliative care teams was required.

Educating staff was also seen as a way to promote advanced care planning and respecting patient's wishes. Training was also noted as something that GPs may require to support this process. Some participants felt there needed to be a better process in place once residents reach the RACF. Residents were arriving at the RACF at a later stage of illness and as such RACFs were doing more palliative care. It was important for families that the RACF get the terminal phase right. Education for families and residents was also noted as an area of need by one participant.

It was felt that RACFs needed to be well equipped to provide a high level of care and quality outcomes for the resident. Some participants thought that a national approach was required that was more responsive and holistic. Aged care workers in general therefore need the skills to address different palliative care needs. In particular one participant felt that there was a need for more skilled staff in RACFs:

*Palliative care will be core business for RACFs - we have up to 3 or 4 palliative patients at any one time here. You can't provide excellent palliative care without the use of RNs. Specialist units are chock a block and only have a few beds so patients end up in the acute care sector blocking beds. However, RNs cost money (the hourly rate is twice as much as an AIN). RACFs are run as a business in a competitive market and they need to make money. There seems to be a reluctance to employ RNs.*

Better facilities for families to be with residents was also argued for by some participants. This included separate facilities for terminal patients where their families could be with them. For example:

*We need to look at having an environment where families can stay and be involved. We need a separate area, a palliative care wing like the hospice model.*

*It is important to have a place where families can stay at end stage. We need more rooms to facilitate this. We need to update facilities and have more capacity to allow families to stay overnight.*

### **Is there anything else that you would like to add?**

Only two participants had something extra that they wished to add about the initiative. One participant stated that the initiative had been 'very positive personally' and the training 'fantastic'. Another participant argued that resources and education were crucial to the initiative and that education was well received by staff. It was also noted that on-line education would also be helpful.



## APPENDIX 4 - NATIONAL ROLL-OUT PROJECTS: SURVEY ANALYSIS

### 1 Methodology

At least three months after attendance at a workshop, participants were emailed a link to a SurveyMonkey® survey:

- Champions for Skin Integrity (CSI) survey response rate: 299/789 (37.9%) – completed between 8 April 2014 and 14 January 2015.
- Palliative Approach Toolkit survey response rate: 278/2,013 (13.8%) – completed between 30 July and 26 October 2014.

### 2 Summary of results

Results of analysis of the survey data relating to the CSI and Palliative Approach Toolkit, were extremely positive. On the whole, the workshops either met or exceeded the expectations of respondents. It is also clear that the vast majority of respondents felt that the workshop duration was appropriate and that resources used during the workshop assisted their learning.

### 3 Champions for Skin Integrity (CSI) survey results

Respondents were asked to rate the workshop in terms of meeting their expectations. Figure 5 shows that the workshop met, exceeded or greatly exceeded the expectations of the vast majority of respondents (n=291, 97.3%). Only 2.7% of respondents felt the workshop either did not meet their expectations or were unsure.

**Figure 5** CSI workshop meeting expectations

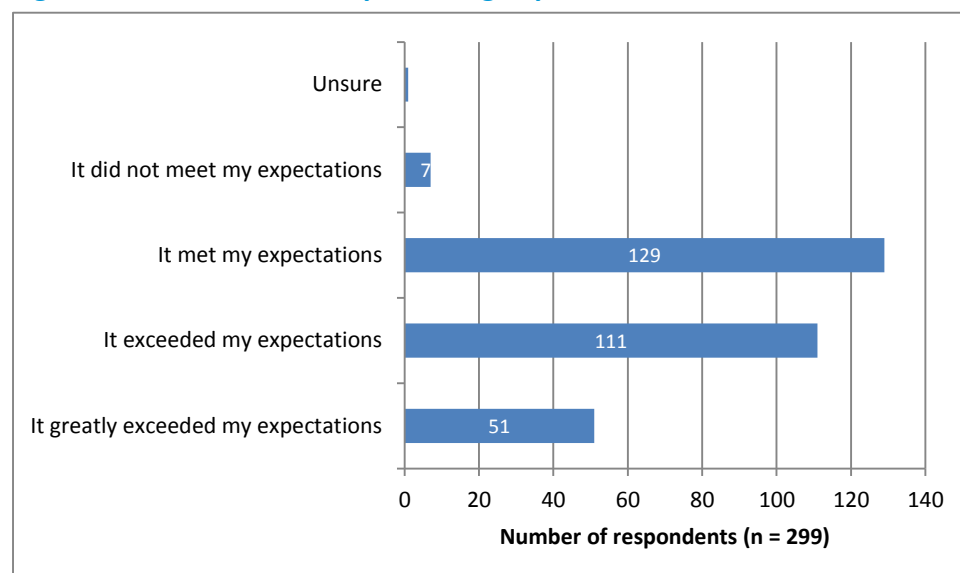


Figure 6 shows the majority of respondents felt PowerPoint slides, handouts and other resources used during the workshop assisted their learning, with 283 (94.6%) respondents in either agreement or strong agreement.

**Figure 6** CSI PowerPoint slides, handouts and other resources used during workshop assisting learning

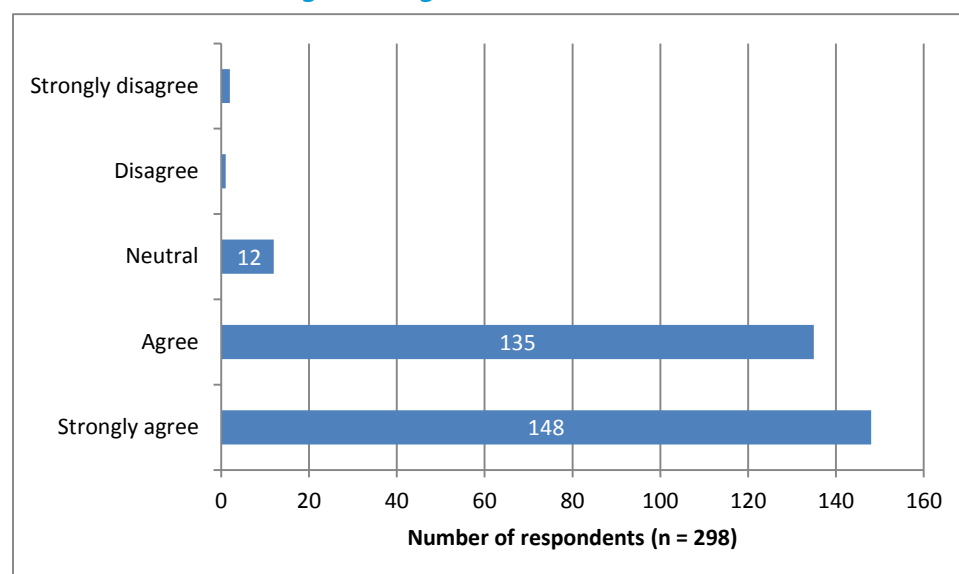
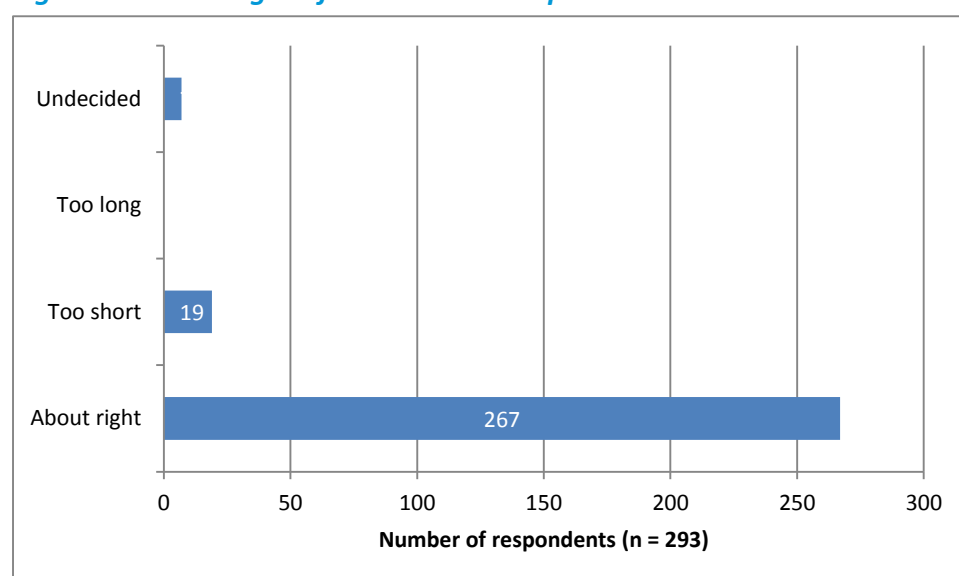


Figure 7 shows that the majority of respondents felt that the length of the workshop was 'about right' (n=267, 91.1%). Only a small number of respondents (n=19, 6.5%) felt the workshop was too short. No respondents felt the workshop was too long; however, seven were undecided about the appropriateness of the length of the workshop (2.4%).

**Figure 7** Length of the CSI workshop



266 respondents provided a response to the question 'What was most valuable about the [CSI] workshop?' A variety of aspects of the CSI workshop were identified as most valuable. Overwhelmingly, most respondents felt the CSI resource kit itself was most valuable. Receiving up to date evidence-based best practice information and guidelines and learning what is contained in the kit and how to use the resources was also valued by respondents. Being able to take the resources contained within the kit away was also clearly appreciated by attendees, and allowed them to be shared with colleagues. One respondent described the resource kit as 'a great tool for disseminating information', and indicating the extent of

dissemination, another respondent encouragingly stated ‘the resource is extremely valuable and is being used widely across our facility’. Other pertinent comments in relation to the resource kit were that: it ‘helps with applying the skills to everyday practice and assists with education of peers’; it ‘improves clinical workflows and consistency of practice’; and ‘other resources that have been introduced without an implementation strategy have not been as successful’. Numerous respondents noted the kit was easy to understand, accessible and user friendly.

More generally, the up-to-date information provided at the workshop was valued by respondents, including information on evidence-based practice and wound management, creating change in the workplace and project planning. Learning new knowledge and skills, or reinforcement of existing knowledge and skills, was also seen by many as a benefit of the workshop, as was ‘bringing back to the facility the extra skills to be able to train others in becoming CSIs’.

Networking was also identified by a very large number of respondents as the most valuable aspect of the workshop. As one respondent commented, ‘the ability to network with interdisciplinary team members from all over Australia’ was most valuable.

In terms of delivery of the education, group learning was valued by many (e.g. ‘small group activities were really helpful in solidifying what was discussed’), as was interaction with and learning from people from other facilities. Similarly, the educators/speakers/presenters were valued, and their education delivery style and content knowledge was praised. Some respondents valued the varied presentation styles (including group work, case studies, lectures and handouts). The following quote is illustrative of this response:

*The way in which information was presented was easy to absorb, to the point and it organised wound/skin care into manageable steps for ongoing teaching purposes.*

When asked ‘**What was least valuable about the [CSI] workshop?**’ 192 respondents answered, of which 139 (72.4%) said nothing was least valuable, because, as many of these respondents stated, ‘all was relevant and valuable.’ Of the respondents that did identify least valuable aspects, small group sessions were most commonly identified (n=12). However, as discussed earlier, and as can also be seen in Figure 8, many respondents found the group learning (including small group sessions) to be the most valuable aspect of the workshop, reflecting differences in individual learning preferences. Other least valuable aspects mentioned by at least two participants were:

- Location and venue (e.g. travel to location was difficult, room was too small for number of participants)
- Length of workshop was too long (e.g. could be a half-day workshop)
- Length of workshop was too short (e.g. could be a two-day workshop)
- Insufficient information on certain topics (e.g. more information required on wound identification and dressing types)
- Too aged care specific (e.g. less relevant for GPs and others in acute settings).

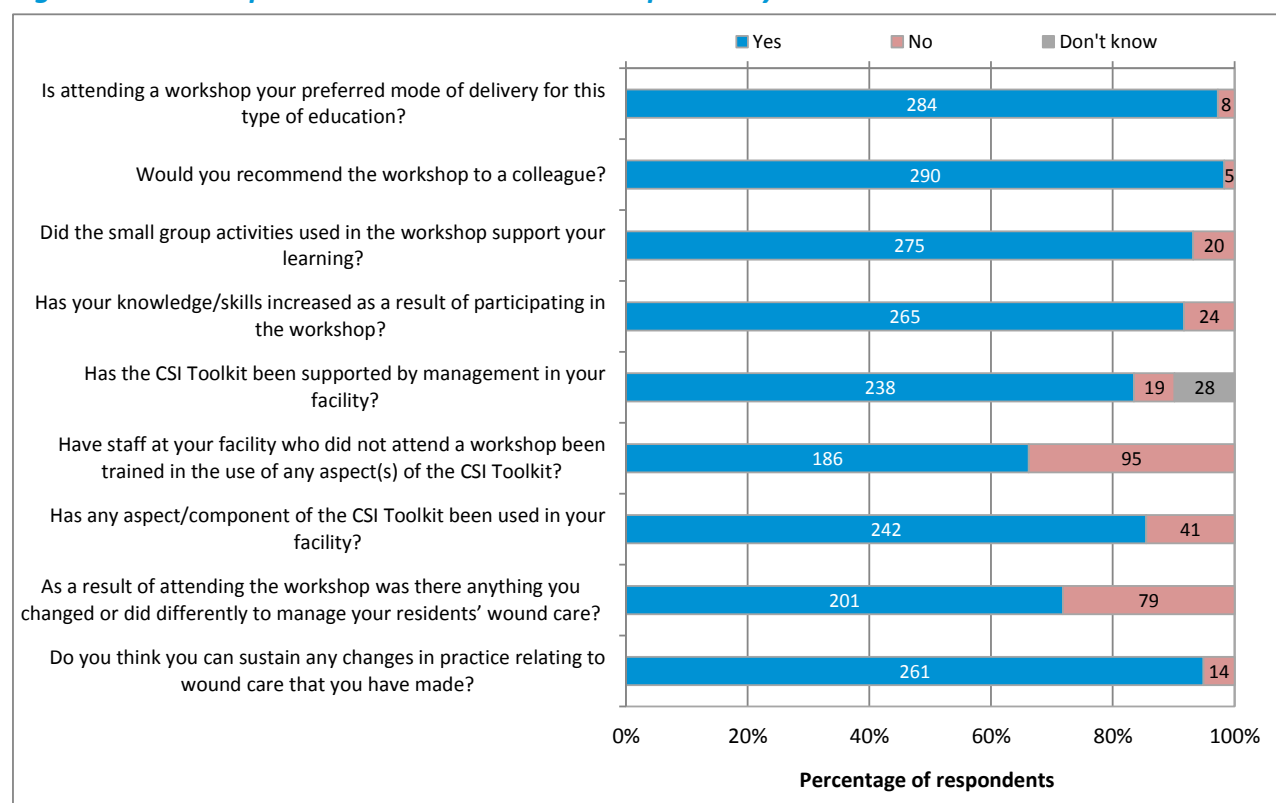
Figure 8 shows responses to nine ‘yes-no’ questions. The vast majority responded particularly positively to the majority of questions, indicating that, overall, the workshop was a success. Specifically:

- Attending a workshop was the preferred mode of delivery of this type of education for almost all respondents (n=284, 97.2%). Other modes suggested as appropriate were: online learning, hands-on training, video, workshops without group work and eLearning or another form of distance learning which issues certificates of completion when finished.
- Almost all respondents would recommend the workshop to a colleague (n=290, 98.3%).
- Small group activities used in the workshops supported the learning of most participants (n=275, 93.2%).
- 265 (91.7%) respondents reported that their knowledge/skills increased as a result of participating in the workshop. Various examples of increased knowledge/skills were provided by 113 respondents, including (but not limited to): dressings for different types of wounds, categories of skin tears, use of evidence based information, implementing a plan and using a team approach for change, change leadership. A number of respondents also noted that existing skills and knowledge were reinforced or refreshed.
- The CSI toolkit has largely been supported by management (n=238, 83.5%). Of those who indicated that it was not supported or did not know, reasons given included already having tools of a similar nature in place, lack of interest from management, budget constraints not allowing for purchase of specific dressing types, change in management, management or organisational structure, and organisations being typically slow to adopt new practices as new policies and practice statements need to be developed. However, the majority of respondents who provided reasons indicated that progress was being made in terms of implementation strategies and seemed optimistic that managerial support would be obtained.
- 242 (85.5%) respondents indicated that the CSI toolkit (at least one aspect/component of it) had been used within their facility, and gave various examples of how it had been used. Respondents who had not used any component of the toolkit provided several reasons why it had not been used. The main reasons were that it was too soon after the workshops, as staff had not yet been educated, the toolkit had not yet been implemented, or there had been competing priorities (such as preparing for accreditation and training new staff due to staff turnover). More negatively, a small number of respondents noted the toolkit had not been used due to reluctance from management, with one remarking the manager felt threatened.
- Most respondents were optimistic about sustaining any changes in practice relating to wound care that they had made (n=261, 94.9%). Of those who indicated they were not optimistic, a number of barriers to the sustained use of this initiative were identified. These included: staff resisting change with many 'set in their ways', lacking time and resources to educate staff (including new staff), lack of managerial support, local politics, lack of change champions, mandated hospital procedures meaning the toolkit can only be used as a resource (and is therefore not promoted in a sustainable way), and changing suppliers resulting in different products for dressings.

Two questions received less positive responses however. These were **'Have staff at your facility who did not attend a workshop been trained in the use of any aspect(s) of the CSI Toolkit?'** and **'As a result of attending the workshop was there anything you changed or did differently to manage your residents' wound care?'** These less positive results suggest

that greater focus on dissemination, training and change management may be required. The fact that 28.2% of respondents reported that no change in wound care had occurred is disappointing, but perhaps not unexpected, due to the complexities of implementing change in workplace practices.

**Figure 8** Responses related to CSI workshop delivery and outcomes



Respondents were asked whether they have '**Anything else to add**', to which 115 responses were provided.

Most final comments were positive and included expressions of gratitude for the opportunity to participate and compliments about the workshop and resources, which was widely seen as worthwhile, informative and useful. Many respondents mentioned they looked forward to putting new skills into practice or felt encouraged by knowing their existing practices were aligned with best practice. Many were eager to attend more workshops in the future, with some adding that other topics would be valuable and that training should be provided more frequently and should also be provided in rural and regional areas. Further training was also seen as important as a means of being informed of developments and changes to maintain best practice. Another common theme was that of increased confidence; in practicing wound management and also in training other staff. Several respondents also gave thanks for additional resources that were sent following the workshop. A small number of respondents noted that recent wound management quality data at their facility/service showed that more wounds had been healed since utilising the resources from the workshop. Others commented on management and staff being very supportive of the changes, resulting in less skin tears, better healing outcomes and using less wound care products.

The following quote is illustrative of positive comments:

*The work shop has helped me get my enthusiasm back that I have always had for wounds, and lost over the past 18 months with the last manager. I now have a new spark and have organised the treatment room back to being a very functional area that is easy to use. I will try to put into practice the components in the resource pack and pass on the knowledge to the other RNs and ENs here.*

Another positive example is:

*This is an excellent toolkit and provides the aged care sector an extremely valuable resource which is easy to apply. This type of resource is so valuable in the aged care sector as staff lack time in researching and preparing resources to this quality.*

One respondent noted they have used the same format to develop other teams e.g. palliation, incontinence, infection control.

Illustrative of the adoption of the toolkit in services, one respondent stated:

*The resource kit has been welcomed by our RNs and ENs and all are to complete the training package. Resource kits have been placed in each Clinical area. We have set up a 'Champions for Skin Integrity' group with representation from care workers, RNs and ENs from across the facility and varying shifts. Everyone has embraced their roles and we have seen changes in practices - more staff awareness of preventative measures and requests for equipment.*

Final comments from some respondents pointed out areas for improvement. These included:

- More time needed with more practical examples of dressing technique using the various products.
- More information needed to be directed at GP nurses.
- More workshops to be offered with a longer lead time so people could get organised to send staff or appropriate people to attend, with more advertisement.
- Include page numbers in kit booklet.
- More information needed on excoriation and rashes and treatment, as they are key skin integrity problems in aged care.
- Toolkit information (or part thereof) to be summarised and made available on a USB stick or DVD.
- Initial difficulty in copying DVDs to give to staff and difficulty navigating the DVD to find files.
- Eight modules are too long to do at work.
- Ensure participants joining the workshop at short notice receive a certificate of completion.

## 4 Palliative Approach Toolkit survey results

Respondents were asked to rate the workshop in terms of meeting their expectations. Figure 9 shows that the Palliative Approach Toolkit workshop met, exceeded or greatly exceeded the expectations of the vast majority of respondents (n=272, 98.5%).

**Figure 9** *Palliative Approach Toolkit workshop meeting expectations*

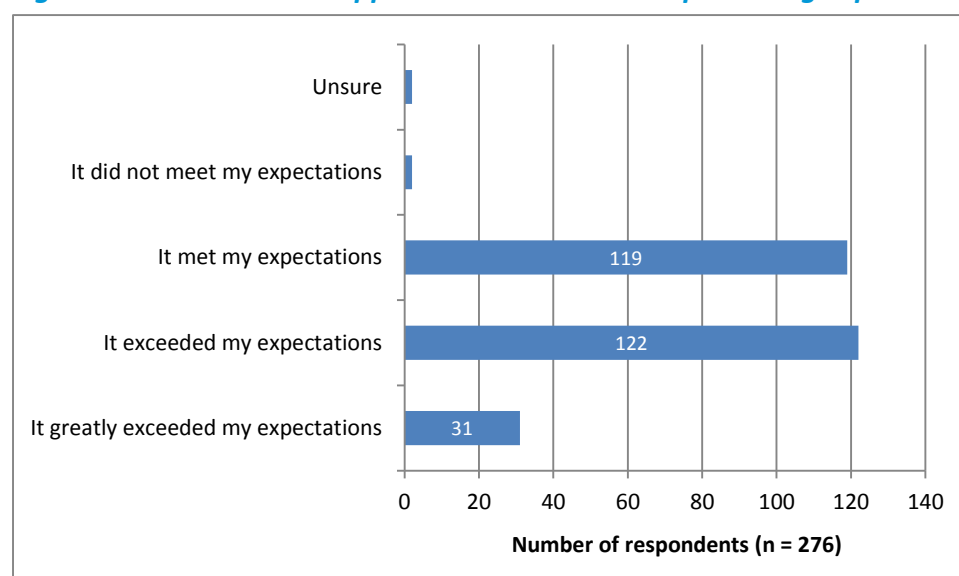


Figure 10 shows that the majority of respondents felt PowerPoint slides, handouts and other resources used during the workshop assisted their learning, with 264 (94.9%) respondents in either agreement or strong agreement.

**Figure 10** *Palliative Approach Toolkit PowerPoint slides, handouts and other resources used during workshop assisting learning*

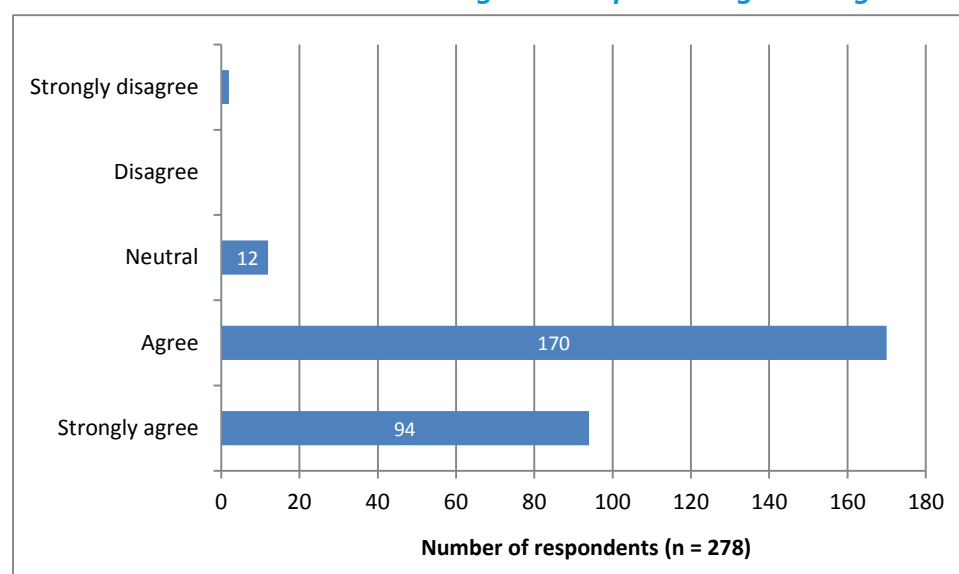
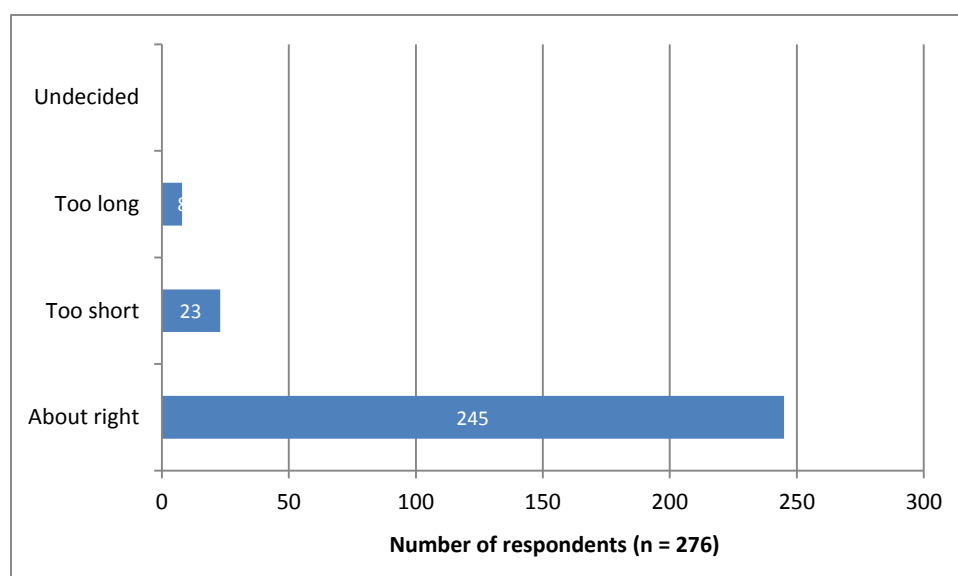


Figure 11 shows that the majority of respondents felt that the length of the workshop was 'about right' (n=245, 88.8%). Only a small number of respondents (n=23, 8.3%) felt the workshop was too short, and even fewer felt the workshop was too long (n=8, 2.9%)

**Figure 11** *Length of the Palliative Approach Toolkit workshop*



230 respondents provided a response to the question **‘What was most valuable about the [Palliative Approach Toolkit] workshop?’** A variety of aspects of the Palliative Approach Toolkit workshop were identified as most valuable. Overwhelmingly, most respondents felt the Palliative Approach Toolkit itself was most valuable. It was seen as a great resource which could be utilised in the workplace by all staff, not just those in attendance at the workshop. The documentation and materials contained within the toolkit, for instance end of life care pathways, were seen by many to be very useful. Learning about the different components of the toolkit and how to utilise them was also valued.

Another common positive theme was the delivery of the workshop, in particular the high quality presenters, who were described as experienced, passionate and interactive. The ability to ask the presenters questions and receive thoughtful responses was also valued.

The opportunity to network with staff from other facilities was another key theme that emerged. Many respondents noted that they valued the chance to have discussions with colleagues and learn from each other’s experiences.

A number of respondents seemed to be encouraged by what they learnt at the workshop confirming to them that they were ‘on the right track’ in terms of their palliation practices.

While the knowledge and skills acquired were important to many, others found the workshop revealed to them the significance of evidence based palliative care. For example one respondent stated ‘[the workshop] enhanced my awareness of the importance of providing a high standard of palliative care in aged care facilities’.

Several respondents noted that all aspects of the workshop were valuable.

When asked **‘What was least valuable about the [Palliative Approach Toolkit] workshop?’** 164 respondents answered, of which 104 (63.4%) said nothing was least valuable, because, as many of these respondents stated, ‘All was valuable’. Of the respondents that did identify least valuable aspects, most commonly identified was that the length of workshop was too



short (although as shown in Figure 11 this was a relatively small proportion of respondents) and problems with the venue (e.g. seating arrangements, too many attendees, audio problems), by nine respondents respectively. Five respondents identified small group sessions as least valuable, however, as discussed earlier group sessions were identified by some respondents as the most valuable aspect of the workshop, and as can also be seen in Figure 12, the majority of respondents found small group activities supported their learning. This reflects differences in individual learning preferences. Other least valuable aspects mentioned by at least two participants were:

- Lack of recognition of existing tools, systems and process to deliver high quality palliative care
- Lack of locally specific / relevant information
- Lack of focus on community care because too much focus on residential care
- Length of workshop was too long
- Not receiving the toolkit or receiving it late
- No information on medications.

Figure 12 shows responses to nine 'yes-no' questions. The vast majority responded positively to most of the questions, indicating that, overall, the workshop was a success. Specifically:

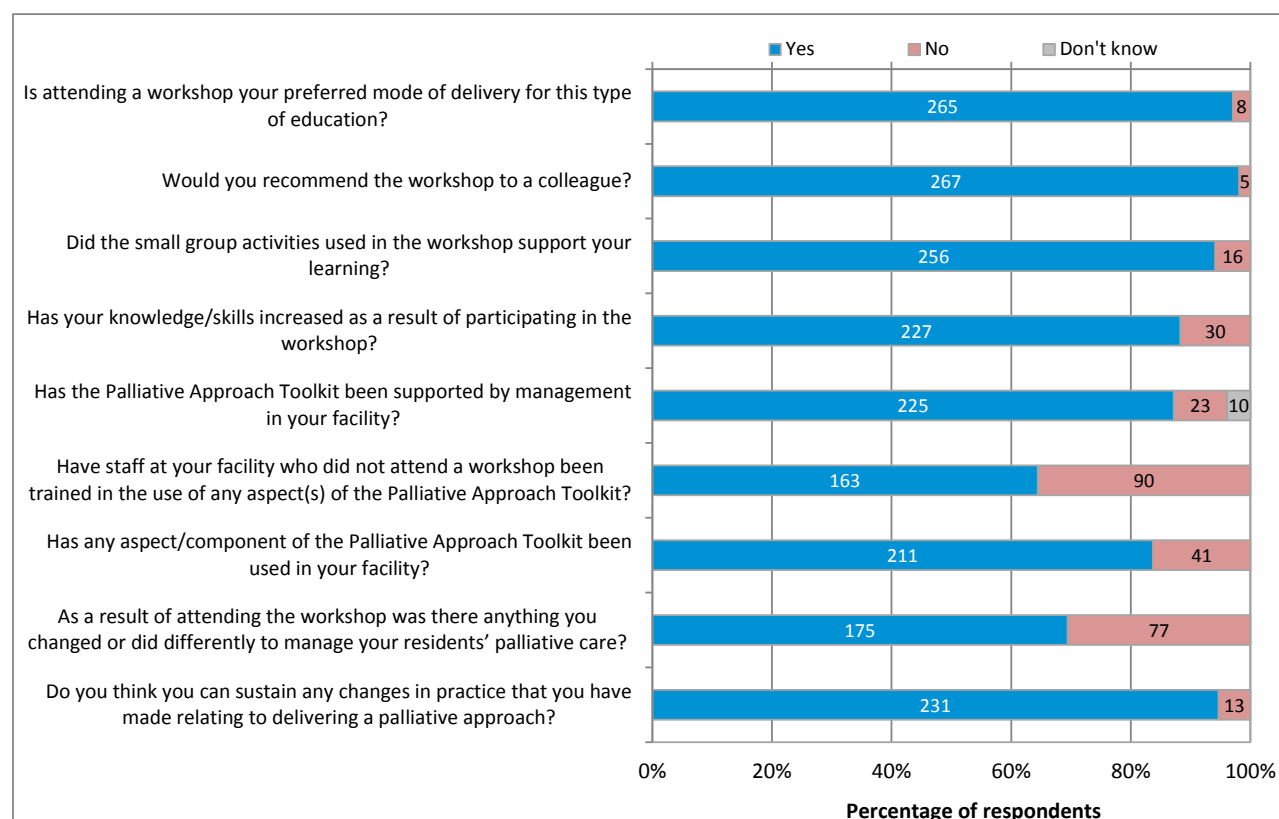
- Attending a workshop was the preferred mode of delivery of this type of education for almost all respondents (n=265, 97.1%). Seven respondents indicated they would prefer an online/webinar format, while hands on training at the facility, having smaller groups, and a workshop conducted locally were each suggested by one respondent respectively.
- Almost all respondents would recommend the workshop to a colleague (n=267, 98.2%).
- Small group activities used in the workshops supported the learning of most (n=256, 94.1%).
- 227 (88.3%) respondents reported that their knowledge/skills increased as a result of participating in the workshop. Various examples of increased knowledge/skills were provided by 74 respondents, including (but not limited to): improved knowledge of the palliative approach generally; more specifically improved knowledge/skills relating to assessment of clients/residents, legal aspects, trajectories, end of life pathways, advanced care planning, pain management, oral care, medications and clinical conferencing. Other examples were improving workplace palliative care documentation, being better able to pass on training to staff, knowledge about commencing and implementing the toolkit in the facility, becoming familiar with tools/resources/support available and greater awareness of the need to support families and share information with colleagues. A number of respondents also noted that existing skills and knowledge were reinforced or refreshed.
- The Palliative Approach Toolkit has largely been supported by management (n=225, 87.2%). Of those who indicated that it was not supported (n=23, 8.9%) or they did not know (n=10, 3.9%), reasons given included already having a palliative toolkit in place, not having infrastructure in place, not having provided training to staff, facility not promoting advance care planning, competing priorities of facility/service (e.g. implementing the Living Well Dying Well project), lack of staffing numbers and lack of time for implementation. Some respondents had changed facility since the workshop

and one respondent did not receive the toolkit. Nonetheless, a number of these respondents who stated the Palliative Approach Toolkit has not been supported by management explained that the issue may be more about delays (e.g. changeovers in senior management delaying formation of a working party and subsequent implementation) and lack of management time, rather than opposition to the toolkit, and felt that support and implementation may be achieved at a later date.

- Twenty-one (83.7%) respondents indicated that the Palliative Approach Toolkit (at least one aspect/component of it) had been used within their facility, and gave various example of how it had been used, including using the resources to develop local information and documentation generally, and more specifically end of life pathways, the implementation guide, the DVDs and using the delirium education for a resident with delirium. Twenty-seven respondents who had not used any component or aspect of the toolkit provided several reasons why it had not been used. The main reasons were that management (and other staff) still required education and engagement to support implementation or that their current practices and approach were adequate and similar to those of the toolkit or that more long-term planning was required. Other respondents stated that implementation was scheduled to commence shortly.
- Most respondents were optimistic about sustaining changes in practice relating to a palliative approach (n=231, 94.7%). Of those who indicated they did not think they could sustain changes in practice, a number of reasons were given. Two respondents cited management as the reason, another two respondents cited no change yet being made, and another two cited lack of time to roll out/support team to sustain change. Other reasons given were lack of education to support staff, the toolkit not being accessible and unwillingness of staff to change practices. One respondent saw the change in practice (and sustaining this change) as a long term endeavour, stating it 'will be a two year project'.

Again, the same two questions that received less positive responses in the Champions for Skin Integrity (CSI) survey were also less positive in the Palliative Approach Toolkit survey. These were **'Have staff at your facility who did not attend a workshop been trained in the use of any aspect(s) of the Palliative Approach Toolkit?'** and **'As a result of attending the workshop was there anything you changed or did differently to manage your residents' palliative care?'** These less positive results suggest that greater focus on dissemination, training and change management may be required, as 35.6% of respondents indicated that facility staff that did not attend the workshop had not been trained in the use of any aspect(s) of the Palliative Approach Toolkit. The fact that 30.6% of respondents reported that no change in palliative care had occurred is disappointing, but perhaps not unexpected, due to the complexities of implementing change in workplace practices.

**Figure 12** Responses related to Palliative Approach Toolkit workshop delivery and outcomes



Respondents were asked whether they have '**Anything else to add**', to which 108 responses were provided.

Most final comments were positive. Compliments about the workshop and the Palliative Approach Toolkit were most common, which were seen by many as high quality and practically helpful. A number of respondents stated it was the best education session they had attended, and that they 'love' the toolkit. The following quotes are illustrative of this positive sentiment:

*Using the toolkit has streamlined and improved palliative care delivery ... staff have fully embraced the use of the toolkit.*

*This training was invaluable to my continued learning and skills set, to ensure the best possible outcome for my residents.*

The supportiveness of local management and palliative care committees was also noted by a number of respondents, which was perceived as important in promoting best practice standards and in the implementation of the Palliative Approach Toolkit.

Despite being positive about the workshop and toolkit, some respondents noted that implementation had not yet occurred. Nonetheless, there seemed to optimism and enthusiasm for implementation from most of these respondents.

Many respondents indicated they would like to attend more education sessions, and a number also stated that the availability of this education needs to increase to more

categories of staff, in all facilities. The need to develop education (and a toolkit) for the community setting was also noted by several respondents. Ongoing support for incremental change was also requested.

Various changes to practice that have occurred since attending the workshop were listed by several respondents, including:

- Increased input from family, residents, pastoral care, nursing and support staff, etc.
- Policies and procedures relating to palliative care reviewed by working parties with improvements made
- Contacted pharmacist regarding emergency stock of medicines
- Increased palliative care education for staff of all categories
- Improved documentation regarding case conferencing
- Family information nights held with resources relating to palliative and end of life care provided and encouragement to complete Advance Health Directives.

The following quote is illustrative of positive comments and demonstrates the significant impact the workshop and toolkit had on some attendees:

*Very worthy project ... Great outcomes for residents and their loved ones ... I'm enjoying aged care nursing much more since the Palliative Approach Toolkit workshop.*

Although describing the workshop and toolkit positively, a number of respondents emphasised that their service already had an adequate palliative approach. For instance, they were already using the end of life pathways, conducting palliative and end-of life case conferences, and utilising advanced care planning.

A small number of final comments highlighted areas for improvement. These included:

- Frustration with the lack of standardisation in palliative care documentation nationally
- Problems claiming case conferences from Medicare due to the requirement of having three multidisciplinary team members present which can be difficult in nursing homes
- Problems with the venue and large attendee numbers
- Delays in receiving resources and delays in feedback (e.g. regarding after death audits)
- Confusion regarding whether after death audits still need to be submitted and if new pathways will be implemented
- More information and education directed at GPs to increase cooperation and support
- Lack of engagement with the workshop and toolkit by AINs despite incentives being offered.

## APPENDIX 5 - CHAMPIONS FOR SKIN INTEGRITY (CSI) SURVEY

The following questions relate to your experiences of attending the CSI Wor...

### 1. Which workshop did you attend?

### 2. Please rate the workshop in terms of meeting your expectations?

- ☐ 1 = Unsure
- ☐ 2 = It did not meet my expectations
- ☐ 3 = It met my expectations
- ☐ 4 = It exceeded my expectations
- ☐ 5 = It greatly exceeded my expectations

### 3. The PowerPoint slides, handouts, and other resources used during the workshop assisted my learning?

- ☐ 1 - Strongly Disagree
- ☐ 2 - Disagree
- ☐ 3 - Neutral
- ☐ 4 - Agree
- ☐ 5 - Strongly Agree

### 4. The length of the workshop was:

- ☐ Too long
- ☐ About right
- ☐ Too short
- ☐ Undecided

### 5. Is attending a workshop your preferred mode of delivery for this type of education?

- ☐ Yes
- ☐ No

If No, what mode of delivery would you prefer?

### 6. Would you recommend the workshop to a colleague?

- ☐ Yes
- ☐ No

### 7. Did the small group activities used in the workshop support your learning?

- ☐ Yes
- ☐ No

**8. What was most valuable about the workshop?**

**9. What was least valuable about the workshop?**

**These questions relate to changes made at your facility as a result of atte...**

**10. Has your knowledge/skills increased as a result of participating in the workshop?**

- ☐ Yes
- ☐ No

If Yes, please provide examples.

**11. Has the CSI Toolkit been supported by management in your facility?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

If No, why has it not been supported?

**12. Have staff at your facility who did not attend a workshop been trained in the use of any aspect(s) of the CSI Toolkit?**

- ☐ Yes
- ☐ No

If No, why haven't they been trained?

**13. Has any aspect/component of the CSI Toolkit been used in your facility?**

☐ Yes

☐ No

If No, why hasn't the Toolkit been used?

**14. As a result of attending the workshop was there anything you changed or did differently to manage your residents' wound care?**

☐ Yes

☐ No

If Yes, please specify changes. If No, why haven't you changed practice?

**15. Do you think you can sustain any changes in practice relating to wound care that you have made?**

☐ Yes

☐ No

If No, what are the barriers to the sustained use of this initiative?

**16. Do you have anything else to add?**

## APPENDIX 6 - PALLIATIVE APPROACH TOOLKIT SURVEY

**These questions relate to your experiences of attending the Palliative Appr...**

**1. Which workshop did you attend?**

**2. Please rate the workshop in terms of meeting your expectations?**

- ☐ 1 = Unsure
- ☐ 2 = It did not meet my expectations
- ☐ 3 = It met my expectations
- ☐ 4 = It exceeded my expectations
- ☐ 5 = It greatly exceeded my expectations

**3. The PowerPoint slides, handouts, and other resources used during the workshop assisted my learning?**

- ☐ 1 - Strongly Disagree
- ☐ 2 - Disagree
- ☐ 3 - Neutral
- ☐ 4 - Agree
- ☐ 5 - Strongly Agree

**4. The length of the workshop was:**

- ☐ Too long
- ☐ About right
- ☐ Too short
- ☐ Undecided

**5. Is attending a workshop your preferred mode of delivery for this type of education?**

- ☐ Yes
- ☐ No

If No, what mode of delivery would you prefer?

**6. Would you recommend the workshop to a colleague?**

- ☐ Yes
- ☐ No

**7. Did the small group activities used in the workshop support your learning?**

- ☐ Yes
- ☐ No



**8. What was most valuable about the workshop?**

**9. What was least valuable about the workshop?**

**These questions relate to changes made at your facility as a result of atte...**

**10. Has your knowledge/skills increased as a result of participating in the workshop?**

- ☐ Yes
- ☐ No

If Yes, please provide examples.

**11. Has the Palliative Approach Toolkit been supported by management in your facility?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

If No, why has it not been supported?

**12. Have staff at your facility who did not attend a workshop been trained in the use of any aspect(s) of the Palliative Approach Toolkit?**

- ☐ Yes
- ☐ No

If No, why haven't they been trained?

**13. Has any aspect/component of the Palliative Approach Toolkit been used in your facility?**

☐ Yes

☐ No

If No, why hasn't the Toolkit been used?

**14. As a result of attending the workshop was there anything you changed or did differently to manage your residents' palliative care?**

☐ Yes

☐ No

If Yes, please specify changes. If No, why haven't you changed practice?

**15. Do you think you can sustain any changes in practice that you have made relating to delivering a palliative approach?**

☐ Yes

☐ No

If No, what are the barriers to the sustained use of this initiative?

**16. Do you have anything else to add?**

Thanks for completing the survey.